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No. _____

In The

Supreme Court of the United States

ARKANSAS DEPARTMENT OF HUMAN SERVICES, *et al.*,

Petitioners,

vs.

HEIDI AHLBORN,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether federal Medicaid law, which requires that a medical assistance recipient assign to the state any right to payment from a third party who is liable for the recipient's medical expenses, and which also prohibits the placement of a pre-death lien upon a recipient's "property," entitles the state to full reimbursement from personal injury settlement proceeds of Medicaid benefits paid on the recipient's behalf, regardless of what portion of the settlement proceeds are designated as compensation for medical care?

PARTIES TO THE PROCEEDING

The parties to the proceeding are:

HEIDI AHLBORN, an individual;

ARKANSAS DEPARTMENT OF HUMAN SERVICES; KURT KNICKREHM, Director of the Arkansas Department of Human Services; WAYNE OLIVE, Director of Third Party Liability Unit, Arkansas Department of Human Services; ROY JEFFUS, Interim Director, Division of Medical Services, Arkansas Department of Human Services.

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BASIS FOR SUPREME COURT JURISDICTION

The United States Court of Appeals for the Eighth Circuit entered its judgment on February 9, 2005. App. 1, 15. Petitioners Arkansas Department of Human Services, *et al.*, seek review of that judgment on a writ of certiorari. The present petition is timely filed pursuant to 28 U.S.C. § 2101(c) and Rule 13.3 of this Court.

This Court has jurisdiction under 28 U.S.C. § 1254(1) to review on a writ of certiorari the judgment of a federal court of appeals.

STATUTES AND REGULATIONS INVOLVED IN THE CASE

42 U.S.C. § 1396a

(a) Contents. A State plan for medical assistance must –

...

(25) provide –

(A) that the state ... administering such plan will take all reasonable measures to ascertain the legal liability of third parties ... to pay for care and services under the plan.

...

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds

the costs of such recovery, the State . . . will seek reimbursement for such assistance to the extent of such legal liability;

. . .

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

42 U.S.C. § 1396k

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this title [42 U.S.C. §§ 1396 et seq.], a State plan for medical assistance shall –

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required –

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights

to . . . payment for medical care from any third party.

. . .

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan.

. . .

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396p

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan.

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan.

Arkansas Code Annotated § 20-77-307

(a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount

which may be paid by Medicaid for the benefits of the applicant.

(b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.

(c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

The following statutes and regulations are set forth in the appendix:

42 U.S.C. § 1382b(a), App. 32.

42 C.F.R. § 430.0, App. 36.

42 C.F.R. § 430.35, App. 36.

42 C.F.R. § 433.140(a)(1), App. 37.

42 C.F.R. § 447.302, App. 37.

Ark. Code Ann. § 20-76-201(1), App. 37.

Ark. Code Ann. §§ 20-77-301 through 20-77-307, App. 38.

S. Rep. No. 99-146 at 312 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312, App. 44.

STATEMENT OF THE CASE

Introduction

Heidi Ahlborn was involved in a motor vehicle accident in January of 1996. App. 2. As a result of the accident, she suffered severe injuries that required extensive medical care. *Id.* During her treatment, Ahlborn applied for and received medical benefits under the Arkansas Medicaid program, which is administered by the Arkansas Department of Human Services ("Department"). *Id.* In total, the Arkansas Medicaid program paid benefits to or on behalf of Ahlborn of at least $215,645.30, which fully compensated her health-care providers. *Id.*

As a condition of her eligibility for Medicaid benefits, Ahlborn had assigned to the Department her "right to any settlement, judgment, or award" that she might receive

from third parties liable for the medical costs resulting from her accident "to the full extent of any amount which may be paid by Medicaid." App. 4. This assignment was made pursuant to Arkansas law, which the State enacted in compliance with a mandate under federal Medicaid law that participating states have in effect such an assignment requirement. App. 8, 9.

Ahlborn filed a personal injury lawsuit against third parties who she alleged were liable for her injuries. R. 29-20, 27.[1] Ahlborn estimated that her damages from the accident totaled approximately $3,040,708.12, which included medical care, loss of earnings and work time, pain and suffering, and permanent impairment of ability to earn in the future. App. 2, 17. Despite inquiries from the Department and its intervention into the lawsuit, Ahlborn reached a compromise settlement of $550,000.00 for her claim without notifying the Department of the ongoing negotiations or involving it in the settlement decision. App. 2; R. 19, 21. The Department subsequently asserted a lien in the amount of $219,156.78 against the settlement proceeds, which represented the amount paid by the Arkansas Medicaid program to or on behalf of Ahlborn to cover her medical expenses resulting from the accident. App. 18 n. 2.

Ahlborn subsequently brought suit against the Department and several of its officials in the United States District Court for the Eastern District of Arkansas seeking a declaratory judgment. App. 3. Specifically, Ahlborn argued that the Department could recover only that portion of the settlement proceeds that represented payment for past medical expenses as opposed to the full amount that the Arkansas Medicaid program had actually paid to her or on her behalf for her medical care resulting from the accident. *Id.* Ahlborn based her argument on a provision of federal Medicaid law – often called the "anti-lien provision" or

[1] "R." refers to the page of the Joint Appendix filed in *Ahlborn v. Arkansas Dep't of Human Services, et al.*, filed in Case No. 03-3377 before the United States Court of Appeals for the Eighth Circuit.

"anti-lien statute" – that prohibits the imposition of a lien "against the property of any individual prior to [her] death on account of medical assistance paid or to be paid on his behalf under the State plan." App. 3, 5. The Department contended that the anti-lien provision did not prevent full recovery, arguing that because Ahlborn had assigned to it as a condition of Medicaid eligibility her "right to any settlement, judgment, or award" paid by a third party liable for her medical costs resulting from the accident, that the settlement proceeds remained the "property" of the third-party tortfeasor until the Medicaid program was fully reimbursed for the funds that it expended on Ahlborn's medical care. App. 5, 6. The Department also explained that if Ahlborn's unliquidated tort claim constituted "property" at the time that she applied for Medicaid, it would have been a "resource" that would have made her ineligible for Medicaid benefits. App. 7 & n. 1.

Adopting the Department's reasoning, the district court held that the federal anti-lien provision did not prevent the Department from recovering from the settlement proceeds the full amount that the Arkansas Medicaid program had paid for Ahlborn's medical care. App. 29, 30. The United States Court of Appeals for the Eighth Circuit overturned this ruling, however, finding that any settlement money that represented something other than compensation for medical care remained Ahlborn's "property" and was thus protected by the anti-lien provision. App. 14.

A. Federal Statutory And Regulatory Background

1. The Medicaid Program In General

Enacted in 1965 as Title XIX of the Social Security Act ("Act"), Medicaid is a publicly funded program that pays for needed medical care for people whose income and resources are insufficient to meet the cost of the required care. *See generally* 42 U.S.C. §§ 1396-1396v; *Atkins v. Rivera*, 477 U.S. 154, 156 (1986) (citation omitted). The primary purpose of the Medicaid program is to provide federal financial assistance to states that elect to reimburse certain costs of

medical treatment for needy individuals. *Harris v. McRae*, 448 U.S. 297, 301 (1980). Congress intended Medicaid to be "the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." *See e.g.*, S. Rep. No. 99-146 at 312 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312. Sound policy and fiscal considerations underlie Congress's intent, including ensuring that sufficient funds remain for future Medicaid recipients and lessening the burden on state and federal taxpayers. *See Schweiker v. Gray Panthers*, 453 U.S. 34, 48 (1981) (recognizing "[t]here are limited resources to spend on welfare.").

States such as Arkansas that choose to participate in the Medicaid program, which is jointly funded by the federal and state governments, must comply with the Act's requirements and with regulations promulgated by the United States Secretary of Health & Human Services ("HHS"). *See e.g., Schweiker*, 453 U.S. at 37; 42 C.F.R. § 430.0 (2004). The federal government may penalize a state's non-compliance by a reduction in or the complete withholding of federal funding to the state. *See* 42 C.F.R. §§ 430.35(a)(1) (2004) and 433.140(a)(1) (2004). HHS's Centers for Medicare and Medicaid Services ("CMS"), previously known as the Health Care Financing Administration ("HCFA"), administers the Medicaid program federally. *See generally* 42 C.F.R. §§ 430.0-430.48 (2004). Participating states must submit for CMS's approval a state Medicaid plan. *See generally* 42 U.S.C. § 1396a (2000).

In determining whether an individual is eligible to receive Medicaid, Congress instructed states to consider an individual's income and resources. Although Congress did not define "resources" affirmatively, it excluded from the definition of "resources" certain categories of property. 42 U.S.C. § 1382b(a) (2000). There is nothing in the language of the Act that excludes from "resources" an unliquidated tort claim against a third party. *Id.*

2. Third Party Recovery And Assignment Provisions

The Social Security Act does not authorize the federal government to recover Medicaid expenditures directly from third parties. Instead, the Act protects the federal fisc by explicitly requiring participating states to pursue reimbursement of state and federal medical assistance payments when third parties are responsible for the injuries underlying those expenses. Upon a state's recovery of these expenses, the Act requires that it reimburse CMS for the federal portion of the payments. For example, federal law requires that states take "all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services under the plan" and seek reimbursement "to the extent of such liability." 42 U.S.C. § 1396a(a)(25)(A), (B) (2000). Specifically, the Act requires that:

> In any case where a third party has a legal liability to make payment for [medical] assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, *the State is considered to have acquired the rights of such individual to payment by any other party* for such health care items or services.

42 U.S.C. § 1396a(a)(25)(H) (2000) (emphasis added).

In addition, the Act mandates that each state must require that Medicaid recipients, as a condition of eligibility, assign to the state their rights to payment for medical care from any liable third party. Specifically, 42 U.S.C. § 1396k(a)(1)(A) provides in pertinent part:

> A State plan for medical assistance shall –
>
> (1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required –

> (A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights to . . . payment for medical care from any third party.

42 U.S.C. § 1396k(a)(1)(A) (2000). This provision also places a duty on the recipient to "cooperate with the State" in identifying and helping the State to pursue potentially liable third parties. 42 U.S.C. § 1396k(a)(1)(C) (2000).

The federal assignment provision further mandates that states must be the first to be paid from any third party recovery. Once the state receives reimbursement for medical assistance benefits that it paid to a Medicaid recipient, any remaining amount must be paid to the recipient. Specifically, 42 U.S.C. § 1396k(b) requires:

> [s]uch part of any amount collected by the State under an assignment . . . shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396k(b) (2000).

3. The "Anti-Lien Provision"

A separate provision of the Act, which is commonly referred to as the "anti-lien provision," protects a Medicaid recipient's property from liens related to medical expenditures made under the program during the recipient's lifetime. 42 U.S.C. § 1396p(a)(1) (2000). In relevant part, this provision provides that "[n]o lien may be imposed against the property of any individual prior to his death on

account of medical assistance paid or to be paid on his behalf under the State plan." *Id.*

B. Arkansas's Compliance With The Act's Recovery And Assignment Provisions

Arkansas participates in the federal Medicaid program and has designated the Arkansas Department of Human Services as the single state agency responsible for administrating the State plan. *See* Ark. Code Ann. § 20-76-201(1) (2001). In compliance with the Social Security Act, Arkansas enacted laws under which the State acquires the rights of a Medicaid recipient to receive payments from third parties who are legally liable for the recipient's medical costs; thus, the State receives reimbursement for the medical assistance benefits that it provided to the recipient. *See generally* Ark. Code Ann. § 20-77-301 *et seq.* (addressing third-party liability for medical assistance benefits paid by the Arkansas Medicaid program).

As required by the federal assignment provision, Arkansas law mandates that Medicaid recipients, as a condition of eligibility for benefits, assign to the State their rights to certain payments from liable third parties. Arkansas's assignment and recovery statute provides in pertinent part:

> (a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the [State] Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefits of the applicant.
>
> (b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.
>
> (c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

Ark. Code Ann. § 20-77-307(a)-(c) (2001).

C. Procedural History

1. United States District Court For The Eastern District Of Arkansas

The Department and Ahlborn filed cross motions for summary judgment in the United States District Court for the Eastern District of Arkansas. App. 16. The parties agreed that the issue in the case – the extent to which the State could recover Medicaid benefits that it had paid on Ahlborn's behalf from the personal injury lawsuit settlement – was an issue of statutory construction for the Court. *Id.*[2] In a Judgment entered August 22, 2003, the district court granted summary judgment in favor of the Department, holding that "the Medicaid statute is intended to vest States with the right to recover the full payment of medical expenses by a third party liable for causing the injuries which triggered the need for medical care." App. 30.

As an initial matter, the district court recognized that federal Medicaid statutes were enacted as part of a publicly funded program to provide medical care to individuals lacking the resources to obtain essential medical services, and that the Medicaid program was intended to be the "payer of last resort." App. 19. The district court likewise noted that the State of Arkansas, which subjected itself to compliance with the mandates of the Act and regulations promulgated thereunder by voluntarily electing to participate in this program, enacted its assignment and recovery statute in compliance with the federal mandate set forth in 42 U.S.C. § 1396k. App. 20-21. The court then rejected Ahlborn's argument that the Act's anti-lien provision

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[2] Because Ahlborn and the third parties had not allocated the settlement proceeds among Ahlborn's various claims (i.e., permanent injury, past and future medical expenses, pain and suffering, etc.), the parties to the federal lawsuit stipulated to an allocation in order to enable the federal court to rule on cross motions for summary judgment as a matter of law. App. 16, 17.

limited the Department's right to full reimbursement from the settlement proceeds.

First, the court reasoned that a personal injury settlement that a Medicaid applicant assigns to the Department as a condition of eligibility for medical assistance benefits is not the "property" of the Medicaid beneficiary within the meaning of the anti-lien provision. App. 22, 23, 30. Adopting the reasoning of the highest courts of Utah and Washington, as well as the dissenting opinion of the highest court in Minnesota, the district court explained that "the anti-lien provision drops out of the analysis once a Medicaid recipient assigns his cause of action because the recipient no longer has any interest in the property (his or her action against third parties) to the extent of the state's expenditures." App. 26 (citations omitted).

Next, the district court recognized that the United States Secretary of Health and Human Services, whose federal agency is charged with administering the Medicaid laws in question, has consistently interpreted the Act in the same manner as the State of Arkansas. App. 27. Specifically, the court recognized that the Secretary, which "has not hesitated to enforce its position against participating States," has taken the position that "States must require, as a condition of eligibility, that recipients assign to the State their right to recover from third parties and that, from any such recovery, the State must recover the full amount of benefits paid on the behalf of the recipient." *Id.* (citations omitted). In finding the Secretary's position entitled to "due consideration," the district court cited to cases in which the United States Supreme Court recognized the Secretary's "significant expertise" in the context of this "complex and highly technical regulatory program," and granted the Secretary "exceptionally broad authority" under the Medicaid statute. App. 28 (citations omitted).

Finally, the district court explained that if Ahlborn's lawsuit had been litigated to conclusion or reduced to a sum certain at the time that she had applied for Medicaid benefits, she would have been forced to expend those

monies, or "resources," before she would have qualified for Medicaid benefits. *Id.* The court reasoned that Congress instructed states to consider a Medicaid applicant's income and resources in determining whether the individual is eligible to receive Medicaid benefits. App. 28, 29, *citing* 42 U.S.C. § 1382b. Although Congress excluded certain categories of property from the definition of "resources," the court found that it did not exclude an unliquidated tort claim against a third party. *Id.* The district court thus concluded that a Medicaid applicant's unliquidated tort claim is both a "resource" and "property" for purposes of the Medicaid Act, and consequently, "there is nothing incongruent about requiring an applicant, as a condition of Medicaid eligibility, to assign to the State his entire 'rights to payment from third parties.'" App. 29.

Summarizing its reasoning in support of the Department's interpretation of the Act, the district court explained:

> Section 1396a(a)(25), which [Ahlborn] construes as limiting Arkansas' right of assignment, is harmonized with the remainder of the Medicaid statute by a broader reading. The Medicaid statute requires States to ascertain the "legal liability" of third parties "to pay for care and services" rendered under the Medicaid program, 42 U.S.C. § 1396a(a)(25)(A), and, to pursue recovery to the full "*extent of such legal liability*," 42 U.S.C. § 1396a(a)(25)(B) [district court's emphasis]. Full effect to the statute as a whole is supported by an interpretation of the statutory provisions that does not limit States to the compromise value assigned to the medical expenses component of the assigned claim during settlement negotiations . . . [a]lthough the statutory language in question is far from a model of clarity, when the Court considers the statute as a whole, the Secretary's position on the issue, and the legislative history of the Medicaid statute . . . it concludes that the [Department] ha[s] the better argument. The Medicaid statute is intended to vest States with the right to recover the full payment of medical

> expenses by a third party liable for causing the injuries which triggered the need for medical care.

App. 29-30.

2. United States Court Of Appeals For The Eighth Circuit

The United States Court of Appeals for the Eighth Circuit reversed the district court, finding that "Ahlborn ha[d] the better of the argument." App. 2. Like the district court, the court of appeals recognized that Congress intended Medicaid to be a "payer of last resort," and that the "primary purpose of the [Medicaid] program is to provide federal financial assistance to States that elect to reimburse certain costs of medical treatment for needy individuals." App. 4 (citations omitted). Contrary to the district court, however, the Eighth Circuit found that Ahlborn's unliquidated tort claim remained her "property," and that the federal anti-lien provision thus preempted Arkansas's assignment and recovery statutes "to the extent that they require Ahlborn to assign her rights to recover third-party liability payments for matters other than the cost of her medical care and services." App. 14.

In so ruling, the Eighth Circuit found that the State's assignment and recovery statute "requires recoupment from, and places a lien on, the entirety of third-party payments – not just that portion of the third-party payment for medical care." App. 5. The court rejected the State's argument that its assignment and recovery statute did not conflict with the federal anti-lien provision because federal law *mandates* that states participating in the Medicaid program impose such a reimbursement mechanism. App. 5-6. Turning to 42 U.S.C. § 1396a(25)(H) and 42 U.S.C. § 1396k(a)(1), the court reasoned that the Act mandates only that participating states recover payments made by third parties "to compensate for medical care." App. 10. Specifically, the court explained:

> [w]e believe a straightforward interpretation of the text of these statutes demonstrates that the

> federal statutory scheme requires only that the State recover payments from third parties to the extent of their legal liability to compensate the beneficiary *for medical care and services* incurred by the beneficiary. Under § 1396a(a)(25)(H), a state Medicaid plan must include provisions specifying that, when the State provides medical benefits to an applicant, "the State is considered to have acquired the rights of such individual to *payment by any other party for such health care items or services.*" [court's emphasis]. The acquisition of rights occurs only in cases where a "third party has a legal liability to make payment for [medical] assistance." *Id.* Section 1396k(a)(1)(A) similarly requires that an applicant assign to the State her right "to *payment for medical care* from any third party." [court's emphasis]. Both statutes are thus limited to rights to third-party payments made to compensate for medical care.

App. 9-10.

In so ruling, the Eighth Circuit refused to defer to the HHS Secretary's (HCFA/CMS's) interpretation and implementation of the federal third-party liability provisions. App. 11. Initially, the court recognized that the Secretary's interpretation had twice been upheld by the HHS's Department of Appeals Board ("DAB"). App. 10, 11. Despite its acknowledgement that the Secretary is charged with administering the Act and is entitled to deference "when a statute is ambiguous and the agency advances a reasonable interpretation of the statute," the court found that the agency's interpretation was "inconsistent with the plain language of the [Act]" and thus not entitled to deference. App. 11, *citing Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984).

Finally, the court found that Ahlborn's unliquidated cause of action was not a "resource" that should have been considered in determining her Medicaid eligibility. App. 7 & n. 1. Reasoning that a "resource" in this context is defined as "cash or other liquid assets or any real or

personal property that an individual . . . owns and could convert to cash to be used for his or her support or maintenance," *citing* 20 C.F.R. § 416.1201(a), the court found that Ahlborn lacked the power to convert her cause of action to cash when she applied for Medicaid benefits. App. 7 & n. 1, 8 (citation omitted). The court thus concluded that "although the same cause of action was 'property' . . . it was not a 'resource.'" *Id.* (citations omitted).

ARGUMENT

A. Certiorari Is Appropriate Because A Substantial Conflict Exists Between *Ahlborn* And Decisions Of Several Other Courts

The Eighth Circuit's opinion in *Ahlborn* directly conflicts with rulings of the highest courts of Washington, Utah, and New York, all of which held within the context of the anti-lien provision that states may recover the full amount of Medicaid benefits paid to a recipient from settlement proceeds from a third party who caused the recipient's injuries that necessitated the medical care expenditures. *Wilson v. State*, 10 P.3d 1061 (Wash. 2000), *cert. denied*, 523 U.S. 1020 (2001); *Houghton v. Department of Health*, 57 P.3d 1067 (2002), *cert. denied*, 538 U.S. 945 (2003); *Cricchio v. Pennisi*, 683 N.E.2d 301 (N.Y. 1997) and *Calvanese v. Calvanese*, 710 N.E.2d 1079 (N.Y. 1999), *cert. denied*, 528 U.S. 928 (1999). It likewise conflicts with decisions of the United States Court of Appeals for the Second Circuit and the Supreme Court of North Dakota that federal law authorizes states to obtain *full* reimbursement from third party settlements for the cost of medical benefits paid to a Medicaid recipient. *Sullivan v. County of Suffolk*, 174 F.3d 282 (2nd Cir. 1999), *cert. denied*, 528 U.S. 950 (1999); *Grey Bear v. North Dakota Dept. of Human Services*, 651 N.W.2d 611 (N.D. 2002). Although the recipients in *Sullivan* and *Grey Bear* did not raise the federal anti-lien provision, the courts' reasoning readily transfers to the anti-lien context.

The Minnesota Supreme Court, however, has ruled in a manner consistent with the *Ahlborn* court. *Martin v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003). Due to this conflict over an area of federal law that significantly impacts every state, this often-litigated and critically important issue is ripe for review by this Court.

1. The *Ahlborn* Decision Conflicts With Decisions Of The Highest Courts Of Utah, Washington, And New York That Directly Addressed The Federal Anti-Lien Provision

a. *Wilson v. State* (Supreme Court Of Washington)

In *Wilson v. State*, a guardian *ad litem* brought an action on behalf of a class Medicaid recipients who had filed personal injury lawsuits and received either settlements or judgments in their favor. 10 P.3d 1061, 1063 (Wash. 2000), *cert. denied*, 523 U.S. 1020 (2001). The question before the Supreme Court of Washington was whether state law "which attempts to lien a Medicaid recipient's third party recovery beyond that portion specifically allocated to medical expenses, conflicts with the federal [anti-lien] law and is thus preempted." *Id.* at 1063. Finding no conflict, the court concluded that "the state is not limited to recovery from only that portion of the settlement specifically allocated to medical expenses . . . [t]he federal statute states recovery is to the extent of payment made by the state for health care items or services." *Id.* at 1066.

Addressing the federal anti-lien provision, the court recognized that federal law permitted a statutory assignment of rights to third party payments, and that the Medicaid recipients "assigned the right to payment to the extent paid out by the state." *Id.* at 1064-66. The court explained that because the state's lien was placed on the recovery "before it becomes the property of the Medicaid recipient . . . the [state] does not have a lien on 'property' of the recipient." *Id.* at 1066. The court thus found the federal anti-lien provision to be "irrelevant." *Id.* at n. 2.

b. *Houghton v. Department Of Health* (Supreme Court Of Utah)

In *Houghton v. Department of Health*, the Supreme Court of Utah considered whether the state may place a "priority lien" on third party settlements paid to Medicaid recipients that enable the state to receive full reimbursement for medical costs paid to the recipient before the recipient receives compensation for non-medical claims. 57 P.3d 1067, 1069 (Utah 2002), *cert. denied*, 538 U.S. 945 (2003). Rejecting the recipient's argument that such a lien "could result in a seizure of the recipient's property," the court held that the priority lien did not run afoul of the federal anti-lien provision. *Id.* at 1069.

Citing to the federal anti-lien provision, the court explained that "[i]t is well settled in Utah that liens against third-party settlement proceeds do not violate federal law because settlement payments do not become a recipient's property until Medicaid is reimbursed." *Id.* at 1069 (citations omitted). Thus, the court concluded that "a priority lien on a recipient's third-party settlement proceeds does not encumber the recipient's property, even if those proceeds include compensation for nonmedical claims." *Id.* at 1069.

c. *Cricchio v. Pennisi* And *Calvanese v. Calvanese* (New York)

In *Cricchio v. Pennisi*, New York's highest court considered whether a Medicaid lien placed by the state "on the proceeds of a personal injury settlement must be satisfied before those funds may be transferred to a 'supplemental needs trust.'" 683 N.E.2d 301, 302 (1997). Medicaid recipients argued that the Medicaid lien could not be satisfied until after their deaths based upon the federal anti-lien provision. *Id.* at 304-05. Rejecting that contention, the *Cricchio* court found that because the injured Medicaid recipients had assigned their recovery rights to the state as required by 42 U.S.C. § 1396k, "the settlement proceeds are resources of the third-party

tortfeasor that are owed to [the state]." *Id.* at 305. The court further explained:

> Accordingly, the lien on the settlement proceeds attaches to the property of the third party, and thus does not violate the statutory prohibition against imposing a lien against a beneficiary's property until after his or her death . . . The flaw in the plaintiff's theory that the lien cannot be satisfied until the recipient's death is that it fails to appreciate this critical distinction between the assets of a responsible third party and assets belonging to the Medicaid recipient.

Id. (citations omitted). In so ruling, the court recognized that "the legal liability of any responsible third party to reimburse Medicaid for care . . . is a cornerstone of the Medicaid program." *Id.*

The *Cricchio* court left open the question of whether the entire amount of a personal injury settlement or only that portion attributable to past medical expenses was available to reimburse the state. This question was later addressed in *Calvanese v. Calvanese*, however, in which New York's highest court considered whether "the entire amount of a personal injury settlement [was] available to satisfy a Medicaid lien, or only that portion of the settlement specifically allocated to past medical expenses." 710 N.E.2d 1079 (N.Y. 1999), *cert. denied*, 528 U.S. 928 (1999). The appellants, who had received Medicaid benefits for injuries allegedly suffered due to the negligence of third parties, commenced personal injury actions against the third parties. *Id.* at 1080. When the lawsuits settled, the recipients refused to satisfy the Medicaid liens placed upon the settlements, arguing that the settlement proceeds were designated as payment for "pain and suffering." *Id.*

After analyzing the federal assignment and third party recovery provisions set forth in 42 U.S.C. §§ 1396a(a)(25)(H) and 1396k(b), the court rejected the recipients' argument that only the settlement proceeds specifically allocated to past medical expenses should be made available to satisfy the state's Medicaid lien. *Id.* at 1082. It found that "[n]owhere in the elaborate statutory

scheme governing this area of the law . . . is the agency's right of recovery restricted in this matter." *Id.* at 1081. The court further reasoned that creating such a restriction on the state's ability to recover its Medicaid expenditures "would weaken the assignment and subrogation provisions as well as the priority assigned to Medicaid liens, results that would jeopardize the ultimate goal of Medicaid – that the program be the payer of last resort." *Id.* at 1082. The court also recognized that restricting the state from recovering its medical expenditures from the settlement proceeds "would also create an anomalous situation"; specifically, "Medicaid applicants could be disqualified from eligibility for financial resources that include prior personal injury settlements allocated to pain and suffering, but Medicaid recipients could shield such funds from recoupment by the [state] after having received significant public assistance." *Id.* at 1082.

2. The *Ahlborn* Decision Conflicts With Decisions Of The Second Circuit And The Supreme Court Of North Dakota That Addressed The States' Right To Full Reimbursement For Medical Expenses From Third-Party Settlements

a. *Sullivan v. County Of Suffolk* (United States Court Of Appeals For The Second Circuit)

In *Sullivan v. County of Suffolk*, the Second Circuit held that, based upon the federal assignment statute, a state may first satisfy its lien before any settlement proceeds are placed in a supplemental needs trust for a Medicaid recipient. 174 F.3d 282, 286 (2nd Cir. 1999), *cert. denied*, 528 U.S. 950 (1999). In so holding, the court interpreted the federal assignment language to mean that the Medicaid recipient had "assigned his right to recover from a third party to [the state], *up to the amount of medical assistance provided.*" *Id.* (emphasis added). The court further noted that "the agency is entitled to full recovery once sufficient funds are made available by a responsible third party, regardless of what portion of the settlement is allocated to past medical expenses." *Id.* at

286, n. 5 (*citing Calvanese*, 93 N.Y.2d at 479, 484, 710 N.E.2d 1079).

b. *Grey Bear v. North Dakota Dept. Of Human Services* (North Dakota)

In *Grey Bear v. North Dakota Dept. of Human Services*, the Supreme Court of North Dakota likewise held that the state's recovery of medical assistance paid on behalf of a Medicaid recipient should not be limited to that portion of settlement proceeds allocated to medical expenses, but may extend to settlement proceeds intended to compensate the recipient for pain and suffering. 651 N.W.2d 611, 615 (N.D. 2002). Turning to the federal assignment statutes and state law enacted in response, the court rejected a Medicaid recipient's argument that he had made only a "partial assignment" under the law that encompassed only claims for medical costs but not for pain and suffering. *Id.* at 615. In so ruling, the *Grey Bear* court adopted the reasoning set forth in cases such as *Wilson* and *Calvanese* that reimbursement for medical costs paid is not limited "to recovery allocated specifically to medical costs," and that "nowhere in the elaborate scheme governing Medicaid is the agency's right to recovery restricted" to settlement proceeds "specifically allocated to past medical expenses." *Id.* at 615-66, 622 (citations omitted).

3. The *Ahlborn* Decision Is Consistent With That Of The Supreme Court Of Minnesota

In *Martin v. City of Rochester*, the Minnesota Supreme Court held in a 4-3 decision that Minnesota's assignment and recovery statute was conflict preempted by the federal anti-lien provision to the extent that it permitted the state to obtain an assignment from a Medicaid recipient for anything more than the recipient's "rights to payment for medical care from third parties liable for the injuries that necessitated medical assistance." 642 N.W.2d 1, 18 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003). In so holding, the court recognized that a Medicaid recipient who assigns his right to recovery no longer holds any "property" right in

the recovery, "and therefore the anti-lien provision does not prohibit a state from pursuing recovery under this assigned right." *Id.* at 13, 14. Reasoning consistently with the Eighth Circuit in *Ahlborn*, however, the *Martin* court determined that the assignment mandate contained in §§ 1396k and 1396a(a)(25)(H) is limited to the assignment of proceeds from a third party for medical care only. *Id.* at 12-13.

The court further held that Minnesota's statutes conflicted with the purpose of the anti-lien provision, which is "to protect the recipient's limited assets, including nonassigned rights to recover." *Id.* at 18. Thus, the court narrowly construed the federal assignment statutes to mean that the state had assignment rights to "all proceeds *for medical care*, but does not have rights in any other part of a recovery." *Id.* at 19 (court's emphasis). Stated differently, the court found that the state cannot recover the full amount of Medicaid benefits that it paid to a recipient, but rather only portions of the recovery that had not been designated as reimbursement for non-medical care damages. *Id.* at 26.

In reaching this result, the *Martin* court (like the *Ahlborn* court) accorded no deference to the United States Department of Health and Human Services interpretations and adjudications concerning the states' ability to use such measures to recover medical expenditures from responsible third parties. *Id.* at 21. Noting that "[d]eference to agency interpretation is called for . . . only when there is an ambiguity in the expression of congressional intent," the court concluded that the statutory scheme at issue was not ambiguous. *Id.* at 21.

B. Certiorari Is Appropriate Because *Ahlborn* Conflicts With Adjudications And Interpretations Rendered By The United States Department Of Health And Human Services

The *Ahlborn* decision directly conflicts with interpretations rendered by the United States Department of Health & Human Services ("HHS"), as well as adjudications of its Departmental Appeals Board ("DAB"). Formal federal agency adjudications, such as those issued by DAB,

are granted full deference when the language of a statute is ambiguous or silent on a particular issue and the interpretation is a permissible construction of the statute.[3] *Chevron, U.S.A. Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 843 (1984). Agency interpretations not contained in regulations or adjudications are due a "respect proportional to [their] 'power to persuade'" given the "'specialized experience and broader investigations and information' available to the agency." *United States v. Mead Corp.*, 533 U.S. 218, 234-35 (2001) (*quoting Skidmore v. Swift & Co.*, 323 U.S. 134, 139-40 (1944)).

The United States Supreme Court addressed the level of deference accorded to HHS interpretations of Medicaid program provisions in *Wisconsin Dep't of Health and Family Services v. Blumer*, 534 U.S. 473 (2002). In *Blumer*, this Court held that Wisconsin's use of an "income first" method, which HHS had specifically authorized in a "Regional State Letter," was a permissible approach under federal law for determining an institutionalized spouse's Medicaid eligibility. Upholding the method, this Court noted that respectful consideration of a federal agency's interpretation is especially appropriate for the federal Medicaid agency based upon its "significant expertise" in "a complex and highly technical regulatory program." *Id.* at 497 (*quoting Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994)). Furthermore, this Court recognized the long-standing principle that Congress delegated

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[3] HHS's adjudications and interpretations satisfy the second prong of the *Chevron* test, which requires that the agency's interpretation be a "permissible construction of the statute." 467 U.S. at 843. These adjudications and interpretations are permissible because they underscore the federal law requirement that states be given broad authority to pursue third party recoveries. *See* 42 U.S.C. § 1396a(a)(25)(A) (2000); *Wisconsin Dep't of Health and Family Services v. Blumer*, 534 U.S. 473 (2002) (allowing for a permissible range of choices to the States in implementing the Medicaid program where HHS has found that such latitude is consistent with the statute's aims). Furthermore, HHS's adjudications and interpretations support Congress's intent that Medicaid be the "payer of last resort." Senate Report No. 99-146, at 312 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 279. App. 44.

"extremely broad regulatory authority to the Secretary [of HHS] in the Medicaid area." *Id.* at 497, n. 13. Accordingly, this Court observed that "the leeway for state choices urged by both Wisconsin and the United States is characteristic of Medicaid." *Id.* at 476.

1. HHS's Departmental Appeals Board Decisions, Which Are Entitled To Deference, Conflict With The *Ahlborn* Decision

The *Ahlborn* court failed to accord appropriate deference to two decisions of HHS's DAB concerning the breadth of the federal assignment provision. In *California Dep't of Health Services*, HCFA (CMS's predecessor) opposed California's practice of permitting recipients to keep portions of third party recoveries that did not represent payment for medical care. DAB No. 1504 (1995); App. at 68. The DAB upheld HCFA's interpretation, concluding that federal Medicaid law requires full Medicaid reimbursement before a recipient may collect any proceeds from a third party settlement. App. at 69, 75. In so ruling, the DAB explained that HFCA's position was "directly supported" by the Social Security Act; specifically:

> [r]ecipients, as a condition of eligibility, must assign their rights to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to the recipient. While [42 U.S.C. § 1396k(a)] refers to assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.

App. at 76 (emphasis added). The DAB also recognized that this position was not unfair to the Medicaid recipients:

> If Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements . . . where Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.

App. at 85.

The DAB reached a similar result in *Washington State Dep't of Social & Health Svs.*, in which it upheld HCFA's determination that, under the mandatory federal assignment provision, Medicaid must be reimbursed in full before the recipient receives any settlement monies. DAB No. 1561 (1996); App. at 45. The Board explained:

> Where there is a third party that is responsible for payment of a recipient's medical expenses, the recipient may not recover money for him/herself until the federal government is reimbursed for its expenditure of the recipient's medical care.
>
> . . .
>
> HCFA may require a state to assert a collection priority over funds obtained by Medicaid recipients in [third party liability] suits even though the distribution methodology set forth in [42 U.S.C. § 1396k(b)] refers only to payments collected pursuant to assignments for medical care.

Id. The DAB further stated unequivocally: "In cases where a third party has caused the need for medical care and is liable for payment, the Act looks to the third party to reimburse the public." *Id.*

2. HHS's Interpretation Of Medicaid Law, Which Is Entitled To Deference, Allows States To Place Liens On Settlements With Third Parties For The Full Amount That The Program Paid To The Recipient

Additionally, HHS, through HCFA/CMS, has clearly and repeatedly confirmed that the federal anti-lien provision does not prohibit states from placing liens on

third party settlement proceeds to compensate the Medicaid program for the entire amount of medical costs that it paid to a recipient. For example, HCFA explained in a letter to states issued September of 1994 that although federal law prohibits a state "from imposing liens against the property of an individual prior to his/her death because of medical assistance paid on his/her behalf," states are nonetheless required to seek reimbursement from the proceeds of any legal action brought by the recipient "even though [the state] may not have been a party to the litigation." HCFA letter entitled "Third Party Liability Relationship to Liens" (issued September 2, 1994), App. 87, 88. In this letter, HCFA instructed:

> [states] have an interest in the potential personal injury settlement when a recipient's right to recover payment for medical care must have been assigned to [the state] . . . in order for him/her to be eligible for Medicaid. In that event, if you place a lien on these funds, it does not violate the [federal anti-lien] statute.

App. 88.

Likewise, in an HHS letter to states issued in June of 1998 the agency left no doubt that a Medicaid recipient has a right "only to the remainder" of any recovery from a liable third party "after Medicaid payments are fully reimbursed." HCFA letter entitled "State Third Party Liability (TPL) Subrogation Legislation" (issued June 1, 1998), App. 91. The letter instructed that the Social Security Act "does not authorize any payments to the recipient until Medicaid is fully repaid." *Id.*

C. Certiorari Is Appropriate Because This Case Involves An Important Question Of Federal Law That Has Not Been, But Should Be, Settled By This Court

A ruling by this Court regarding a state's authority under federal law to recover the full amount of its Medicaid dollars expended from third party settlement proceeds through use of existing third party recovery methods

such as liens is an issue that has been regularly litigated over the past several years, is of major significance to the states for both financial and planning purposes, and is one that is ripe for review by this Court.

1. This Case Presents A Question Of Significant National Importance

The often litigated issue[4] in this case is of significant national concern, particularly at a time when the level of federal funding of the Medicaid program is decreasing. The *Ahlborn* decision calls into question the legitimacy of assignment and recovery statutes throughout the country, and likewise challenges the ability of all states to define the manner in which they will recover Medicaid expenditures as required under federal law. For apparent fiscal reasons, federal law requires Medicaid participating states to pass laws to ensure that the state acquires the rights of a Medicaid recipient to receive reimbursement from any third party who is liable for medical costs that the Arkansas Medicaid program paid on behalf of the recipient. 42 U.S.C. § 1396a(a) (2000); 42 U.S.C. § 1396k(a), (b) (2000). These same laws allow the states to define the manner in which they will recover these payments. Nothing in the federal Medicaid statutes, however, supports the *Ahlborn* court's finding that the federal anti-lien provision limits the state's recovery to that portion of a settlement that is designated or allocated as recovery for medical expenses.[5]

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[4] *See supra* at 16-21; *see also Padgett v. Toal*, 81 S.E.2d 744, 745-46 (Ga. Ct. App. 2003) (state entitled to recover the full amount of medical costs paid to Medicaid recipient from proceeds of third party personal injury settlement award; full recovery does not run afoul of federal anti-injunction provision).

[5] In the contexts of Medicare and the Federal Employees Compensation Act, courts likewise have found the government entitled to full reimbursement. *See Zinman v. Shalala*, 67 F.3d 841 (9th Cir. 1995) (court rejected Medicare beneficiaries' argument that they were entitled to proportionate distribution of third party recoveries); *United States v. Lorenzetti*, 467 U.S. 167, 176 (1984) (finding government entitled to full reimbursement in FECA case, court explained "[a]t no point did

(Continued on following page)

The issue in the present case is not limited to a few states. To the contrary, every state has passed a lien, assignment, or subrogation law – or some combination of the three – in order to comply with the federal assignment mandate. Several state third party liability statutes, including Arkansas's, provide that the state is entitled to full recovery of medical assistance benefits paid to a Medicaid recipient before the recipient may retain any settlement proceeds for his or her other claims. *See e.g.*, Ark. Code Ann. § 20-77-307 (2001) (state lien is recoverable "to the full extent of any amount which may be paid by Medicaid for the benefits of the applicant"); Alaska Stat. § 47.05-075(a) (2001) (state lien is "upon any sum that may be due to the recipient of medical assistance from a third-party payor"); Cal. Welf. & Inst. Code § 14124.78 (2002) (state's claim is against "the entire amount of any settlement of the injured beneficiary's action or claim"); Mont. Code Ann. § 53-2-612(3)(a)(i) (2001) (state lien "applies to all money paid by a third party . . . regardless of whether the recovery is allocated by the parties or a court to any particular type or element of damages"); 62 Pa. Cons. Stat. § 1409(b)(11) (2001) ("the entire amount of any settlement of the injured beneficiary's action or claim . . . is subject to the department's claim for reimbursement").

Aside from the legal arguments that militate against the *Ahlborn* court's interpretation of federal Medicaid law, such full reimbursement makes perfect sense. A person injured by a third party who is not receiving Medicaid benefits remains liable to his or her medical providers for the full amount of medical services provided; there is no reason why an individual receiving Medicaid should be in a more favorable position. Full reimbursement likewise recognizes the reality that Medicaid dollars are far from being an endless resource and that money reimbursed to

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Congress suggest in its deliberations that the federal right of reimbursement was to be limited to particular categories of third-party recoveries").

the state from third parties may be used to aid other Medicaid applicants in need. The strained interpretation of federal Medicaid law provided by the *Ahlborn* and *Martin* courts, however, is antithetical to purpose and spirit of the Social Security Act: that Medicaid remain the "payer of last resort."

Furthermore, states whose highest courts (or federal district courts) adopt the *Ahlborn* court's reasoning will be forced to intervene directly into all ongoing litigation or file independent causes of actions against third party tortfeasors to recover their Medicaid expenditures.[6] This will result in a substantial increase in expenditures of staff time and financial resources by the State. Requiring states to pursue third parties directly to recover publicly funded medical costs, instead of using lien or subrogation statutes to do so, would force states to spend much more money to recover the same amount of funds. Of course, increased collection expenses reduce the ultimate return to the state and federal government of their medical assistance funds. Stated differently, the *Ahlborn* court's approach would dramatically increase litigation and recovery costs for states, thus leaving less money to return to the Medicaid program for use by applicants in need. In contrast, states whose highest courts (or federal courts) follow the HHS's interpretation of federal Medicaid law will not be forced to litigate their medical assistance third party claims directly, nor will they be prevented from recovering their full claims from a Medicaid recipient's settlement proceeds, regardless of whether those proceeds are designated for "medical care" or not.

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[6] In fact, the State of Arkansas *did* intervene in the state court action below but was not notified by either the plaintiff or third-party tortfeasor of the settlement negotiations. The plaintiff and third-party tortfeasor likewise failed to make the State a signatory to the settlement agreement, rather presenting the agreement to the State as a *fait accompli* and refusing to reimburse the State for the cost of the medical services that it had provided through the Medicaid program to Ms. Ahlborn.

2. The *Ahlborn* Decision Misinterpreted Federal Medicaid Law, Thereby Minimizing A Key Purpose Of The Social Security Act

Certiorari is also appropriate in the present case because *Ahlborn* misinterpreted federal Medicaid law in a way that undercuts the primary purpose of the Medicaid program: to serve as the payer of last resort. A basic principle of statutory construction provides that related statutes must be read *in pari materia*, keeping in mind the purpose of the entire federal scheme, *Erlenbaugh v. United States*, 409 U.S. 239, 243-44 (1972), a principle that the *Ahlborn* decision ignored. The *Ahlborn* court likewise erred in holding that Arkansas's assignment and recovery statute, which requires full reimbursement from third party settlements for a recipient's medical costs paid by the Medicaid program, was preempted by federal law.

The United States District Court for the Eastern District of Arkansas had correctly recognized that "[f]ull effect to the [Medicaid] statute as a whole is supported by an interpretation of the statutory provisions that does not limit States to the compromise value assigned to the medical expense component of the assigned claim during settlement negotiations." App. at 29-30. Overturning the district court, however, the Eighth Circuit erroneously interpreted the anti-lien provision in a manner that denied the Medicaid program its appropriate reimbursement and created a windfall for the recipient. This holding, which is inconsistent with interpretations of the law rendered by the United States Department of Health and Human Services and several other courts, is antithetical to Congress's intention that Medicaid remains the "payer of last resort."

CONCLUSION

For the reasons and based upon the authorities set forth above, the Petitioners respectfully request that the petition for a writ of certiorari be granted.

Respectfully submitted,

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397 F.3d 620

United States Court of Appeals, Eighth Circuit. Heidi AHLBORN, Appellant,

v.

ARKANSAS DEPARTMENT OF HUMAN SERVICES; Kurt Knickrehm, Director of the Arkansas Department of Human Services; Wayne Olive, Director of the Third Party Liability Unit; Roy Jeffus, Interim Director, Division of Medical Services of the Arkansas Department of Human Services, Appellees. **No. 03-3377.**

Submitted: April 13, 2004. Filed: Feb. 9, 2005.

H. David Blair, argued, Batesville, Arkansas (Phillip Farris, on the brief), for appellant.

Richard B. Dahlgren, argued, Little Rock, Arkansas, for appellee.

Before MORRIS SHEPPARD ARNOLD, RILEY, and COLLOTON, Circuit Judges.

COLLOTON, Circuit Judge.

Heidi Ahlborn appeals the district court's grant of summary judgment in favor of the Arkansas Department of Human Services and employees thereof (collectively "the State") in a dispute concerning the extent to which her recovery from a tortfeasor may be taken by the State as reimbursement for the cost of medical care and services provided to Ahlborn by the Medicaid program. After careful review of the various statutes involved, we conclude that Ahlborn has the better of the argument, and we therefore reverse.

I.

Ahlborn was seriously injured in a motor vehicle accident on January 2, 1996. As a result of this accident, she suffered severe personal injuries, especially to her head, which required extensive medical care and rendered her permanently disabled. While under treatment, Ahlborn applied and qualified for medical benefits under the Arkansas Medicaid program, administered in the State by appellee Arkansas Department of Human Services ("ADHS"). In applying for benefits, Arkansas law required Ahlborn to assign to ADHS her "right to any settlement, judgment, or award" she might receive from third parties, "to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." Ark.Code Ann. § 20-77-307(a). In total, ADHS provided Medicaid benefits to or on behalf of Ahlborn in the amount of at least $215,645.30, which fully relieved her debt to health care providers.

The parties agree that Ahlborn's injuries gave rise to claims other than past medical care, including loss of earnings and working time, pain and suffering, and permanent impairment of ability to earn in the future. The parties also stipulated that an estimate of Ahlborn's damages totals approximately $3,040,708.12. However, in mid-2002, Ahlborn was paid $550,000 following a compromise settlement reached through negotiations with her insurance company and third parties allegedly liable for her injuries. This was a lump-sum settlement that did not allocate Ahlborn's recovery among her various claims. The State was not a party to the settlement. The Director of ADHS asserted a lien against Ahlborn's settlement for the amount of benefits ADHS provided, pursuant to Arkansas

Code Sections 20-77-301 through 20-77-313 (third-party liability).

Ahlborn brought suit seeking a declaratory judgment, arguing that ADHS can only recover that portion of her settlement representing payment for past medical expenses. The parties characterize the sole issue in this case as one of statutory construction: whether federal Medicaid statutes, which provide for the assignment of rights to third-party payments, but prohibit placing a lien on a Medicaid recipient's property, limit the State's recovery to only those portions of the payments made for medical expenses. The parties have entered into a stipulation regarding damages, whereby the State will recover $215,645.30 if it prevails on the statutory construction issue, but only $35,581.47 if Ahlborn prevails. This first figure represents the total amount the parties stipulated the State paid in relation to Ahlborn's care. The parties stipulated that the second figure, which represents 16.5 percent of this total amount, is a fair representation of the percentage of the settlement constituting payment by the tortfeasor for past medical care.

The parties filed cross-motions for summary judgment, and the district court granted the State's motion. The court interpreted the relevant federal statutory provisions to mean that the State may recover from Ahlborn's settlement the sum stipulated as the total amount of benefits provided under the Medicaid program, regardless whether the settlement funds represent payments for the cost of medical services. We review the grant of summary judgment *de novo*, applying the same standard as the district court. *Murphey v. City of Minneapolis*, 358 F.3d 1074, 1077 (8th Cir.2004). We will affirm the grant of summary judgment if there is no genuine issue as

to any material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c); *Shelter Ins. Cos. v. Hildreth*, 255 F.3d 921, 924 (8th Cir.2001).

II.

The Medicaid program was established in 1965 by Title XIX of the Social Security Act ("the Act"), codified at 42 U.S.C. § 1396-1396v. The primary purpose of the program is to provide federal financial assistance to States that elect to reimburse certain costs of medical treatment for needy individuals. *See Harris v. McRae*, 448 U.S. 297, 301, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980). States voluntarily agree to participate in the program, but must comply with federal requirements once they do so. *Id.* It is often said that Congress wanted Medicaid to be a "payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S.Rep. No. 99-146, at 312 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 279. The sole issue presented by the parties in this case is whether the Arkansas statutory scheme for recovering Medicaid payments comports with the federal statutes governing how state Medicaid recovery programs must operate. The essential disagreement is whether the State may recover from Ahlborn's settlement any amount beyond that stipulated to be expenses for medical care.

Under Arkansas law, applicants for Medicaid benefits "automatically assign" their rights to "any settlement, judgment, or award which may be obtained against any third party to [ADHS] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." Ark.Code Ann. § 20-77-307(a). "The assignment

shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party." *Id.* § 20-77-307(c). Further, Arkansas Code Section 20-77-302(a) provides that when a Medicaid recipient brings a claim against a liable third party, "any settlement, judgment, or award obtained is subject to the division's claim for reimbursement of the benefits provided to the recipient under the medical assistance program." Arkansas thus requires recoupment from, and places a lien on, the entirety of third-party payments – not just that portion of third-party payments made for medical care.

Ahlborn argues that the Arkansas scheme conflicts with federal law. She relies on 42 U.S.C. § 1396p(a)(1), which prohibits (with certain exceptions not applicable here) the imposition of a lien "against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan[.]" This provision, sometimes referred to as the "anti-lien statute," generally prevents a State from attaching property of a recipient to reimburse the State for benefits paid under a state Medicaid plan. Under the statute's implementing regulation, "property" is defined as "the homestead and all other personal and real property in which the recipient has a legal interest." 42 C.F.R. § 433.36(b).

The State argues that the Arkansas statutory lien "on any settlement, judgment, or award received by the recipient from a third party" does not conflict with the federal anti-lien statute, because the settlement that Ahlborn received from the tortfeasor is not Ahlborn's property. The State contends that because Ahlborn assigned to the State her right to any settlement as a condition of receiving Medicaid benefits, the settlement remains

property of the tortfeasor until the State is fully reimbursed for all funds expended on Ahlborn's medical care. This appears to be the reasoning adopted by the majorities of two divided state court decisions on which the State relies. *Houghton v. Dep't of Health*, 57 P.3d 1067, 1069 (Utah 2002); *Wilson v. State*, 142 Wash.2d 40, 10 P.3d 1061, 1066 (2000).

We believe that Ahlborn's right to a settlement that may be received from a third party, which the Arkansas statute required her to assign to the State, was Ahlborn's "property." Her unliquidated tort claim, in other words, is a form of "personal . . . property in which the recipient has a legal interest." 42 C.F.R. § 433.36(b). "It is basic property law that a chose in action is personal property," and that "the right to sue for damages is property." *Gregory v. Colvin*, 235 Ark. 1007, 363 S.W.2d 539, 540 (1963). The Arkansas assignment statute, moreover, contemplates that the lien arises *after* Ahlborn receives her settlement from the tortfeasor: "The assignment shall be considered a statutory lien on any settlement, judgment, or award *received by the recipient from a third party.*" Ark.Code Ann. § 20-77-307(c) (emphasis added). Thus, whether the State's assignment and lien act upon Ahlborn's cause of action or the settlement she received from the third-party tortfeasors, we see no basis in the governing federal regulations or the common law of property to conclude that the assignment or lien acted upon something other than Ahlborn's property.

We do not believe, moreover, that the State may circumvent the restrictions of the federal anti-lien statute simply by requiring an applicant for Medicaid benefits to assign property rights to the State before the applicant liquidates the property to a sum certain. If the State could

proceed in that manner, then we do not see what limiting principle would preclude the State from requiring a Medicaid applicant to assign to the State other interests in property – such as future wages, lottery winnings, or real property – in order to reimburse the State for health care expenditures under Medicaid. This sort of broad ranging assignment requirement clearly would conflict with the federal anti-lien statute. The State, at oral argument, disclaimed an ability to require a Medicaid applicant to assign unlimited property interests, and relied instead on a narrower justification for the Arkansas statutory lien on recovery from tortfeasors. The State ultimately asserts that because other federal statutes *require* the State to impose the statutory lien created by Section 20-77-307(c), the Arkansas statute cannot conflict with the federal anti-lien statute.[1]

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[1] The State also argues on brief that Ahlborn's unliquidated cause of action is a "resource" that should be considered in determining whether she is eligible for Medicaid benefits in the first place. *See* 42 U.S.C. §§ 1382, 1382b, 1396p(e)(5). The State complains that Ahlborn should not be allowed to "exclude the value of her tort claim to receive benefits and later shield the same resource to defeat reimbursement." (Appellee Br. at 18). We view this argument as largely a red herring, because the State already determined that Ahlborn was eligible for Medicaid benefits, and her eligibility is not at issue in this lawsuit.

In any event, the State's effort to equate "resources" available to an applicant in the eligibility determination with "property" that is shielded from state recovery efforts by the anti-lien statute is not supported by federal or state law. "Resources" is defined by the federal regulation that implements 42 U.S.C. § 1382b as "cash or other liquid assets or any real or personal property that an individual . . . owns and could convert to cash to be used for his or her support and maintenance." 20 C.F.R. § 416.1201(a). An unliquidated personal injury cause of action cannot be sold or assigned, *Mallory v. Hartsfield, Almand & Grisham, LLP*, 350 Ark. 304, 86 S.W.3d 863, 866 (2002), so at the time she applied for benefits, Ahlborn lacked the power to convert her cause

(Continued on following page)

The federal statutes in question provide that a state Medicaid plan must provide that the State acquires the rights of a Medicaid beneficiary to certain payments by third parties, 42 U.S.C. § 1396a(a)(25)(H), and require that a beneficiary assign to the State certain rights to payment from third parties, 42 U.S.C. § 1396k(a)(1). The first statute provides:

> A State plan for medical assistance must –
>
> . . .
>
> (25) provide –
>
> . . .
>
> (H) that to the extent that payment has been made under the State plan for medical assistance in any case where *a third party has a legal liability to make payment for such assistance*, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual *to payment by any other party for such health care items or services.*

42 U.S.C. § 1396a(a)(25)(H) (emphasis added).

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of action to cash for support and maintenance. The Arkansas administrative code, moreover, defines "resource" as any real or personal property "available to an individual to meet his needs," and specifies that "[o]nly those resources currently available, or for which the individual has the legal ability to make available, will be considered." Code of Ark. Rules 016.20.001, Medical Services Policy Manual § 11301 (June 1, 2002). Thus, although the cause of action was "property," 42 C.F.R. § 433.36(b), it was not a "resource." *Cf. Smith v. Ariz. Long Term Care Sys.*, 207 Ariz. 217, 84 P.3d 482, 487 (Ct.App.2004).

The second provision states:

> (a) For the purpose of assisting in the collection of medical support payments . . . a State plan for medical assistance shall –
>
> (1) provide that, as a condition of eligibility for medical assistance . . . to an individual . . . the individual is required –
>
> (A) to assign the State any rights . . . *to payment for medical care from any third party*;
>
> . . .
>
> (C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party *who may be liable to pay for care and services* available under the plan
>
> . . . .

42 U.S.C. § 1396k(a)(1)(A) (emphasis added).

We believe a straightforward interpretation of the text of these statutes demonstrates that the federal statutory scheme requires only that the State recover payments from third parties to the extent of their legal liability to compensate the beneficiary *for medical care and services* incurred by the beneficiary. Under § 1396a(a)(25)(H), a state Medicaid plan must include provisions specifying that, when the State provides medical benefits to an applicant, "the State is considered to have acquired the rights of such individual to *payment by any other party for such health care items or services.*" (emphasis added). This acquisition of rights occurs only in cases where "a third party has a legal liability to make payment for [medical] assistance." *Id.* Section 1396k(a)(1)(A) similarly requires that an applicant assign to the State her right "to *payment*

for medical care from any third party." (emphasis added). Both statutes are thus limited to rights to third-party payments made to compensate for medical care.

Taking the three federal statutes together, we agree with the Supreme Court of Minnesota that the plain meaning of each achieves a harmonious statutory scheme:

> The anti-lien provision protects the personal property of a medical assistant recipient – here, [the plaintiff's] cause of action – from a state's effort to recover for medical expenses. The assignment transfers to the state the recipient's right to recover medical expenses, and therefore the ability to pursue directly potentially liable third parties for medical assistance expenses paid.
>
> The anti-lien provision protects all of a recipient's nonassigned rights to recover. The recovery provision, on the other hand, requires that the state pursue the third parties for medical expenses paid by the state, and the state does so under the assignment.

Martin ex rel. Hoff v. City of Rochester, 642 N.W.2d 1, 13 (Minn.2002). Where, as here, the recipient pursues the third party directly for medical expenses, the recovery provision also allows the State to establish a lien to the extent that a settlement or award constitutes payment by the third party for medical expenses incurred by the recipient.

The State nonetheless urges us to adopt the view espoused by the federal Health Care Financing Administration, and upheld by the Departmental Appeals Board of the Department of Health and Human Services ("HHS") in two adjudications during the 1990s. *See Calif. Dep't of Health Servs.*, D.A.B. No. 1504, 1995 WL 66334 (HHS Jan. 5, 1995) ("*Calif.Dep't*"); *Wash. State Dep't of Soc. and Health Servs.*, D.A.B. No. 1561, 1996 WL 157123 (HHS Feb. 7, 1996) ("*Wash. State Dep't*"). These adjudications conclude that the federal government can require States to attempt to recover from third-party payments beyond those made for medical care.[2]

The parties dispute whether the HHS decisions are entitled to deference under the doctrine of *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984), as an agency's interpretation of an ambiguous federal statute that it is charged with administering. While we agree that an agency's formal adjudication may be entitled to deference in an appropriate case, *cf. Christensen v. Harris County*, 529 U.S. 576, 587, 120 S.Ct. 1655, 146 L.Ed.2d 621 (2000), the principles of deference apply only when a statute is ambiguous and the agency advances a reasonable interpretation of the statute. In this case, we reject the agency's interpretation as inconsistent with the plain language of the statute.

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[2] During the 1990s, some States concluded that a policy of attempting to recover from Medicaid recipients all third-party liability settlements and payments was not the best method to conserve public funds. The State of California, for example, concluded that allowing victims to share in awards "created an incentive to seek out and pursue liable third parties, thereby maximizing pursuit and shifting initial costs from California to the victim." D.A.B. No. 1504, at 13. In decisions involving the California and Washington state Medicaid programs, however, HHS disallowed federal financial participation on the ground that anything less than 100 percent state recovery of third-party liability settlements and payments was inconsistent with federal law.

The HHS adjudications cite three reasons why States can be required to attempt to recover funds from those third-party payments for damages other than the cost of medical care and services. First, HHS reasoned that "[i]n cases where a third party has caused the need for medical care and is liable for its payment, the Act looks to that third party to reimburse the public." *Wash. State Dep't*, D.A.B. No. 1561, at 8; *Calif. Dep't*, D.A.B. No. 1504, at 10. While we agree that the Act looks to third parties to reimburse taxpayer funds, HHS supports its view by noting that States are required under 42 U.S.C. § 1396a(a)(25)(B) to "seek reimbursement for such assistance to the extent of such legal liability." *Wash. State Dep't*, D.A.B. No. 1561, at 8; *Calif. Dep't*, D.A.B. No. 1504, at 10. The phrase "such legal liability," however, refers back to "legal liability" in § 1396a(a)(25)(A), which makes clear that this is "the legal liability of third parties . . . *to pay for care and services available under the plan*[.]" Where, as here, the State seeks reimbursement for amounts payable to the Medicaid recipient for other damages such as lost wages, the text of the Act cited by HHS does not authorize recovery.

Second, HHS concluded that it is reasonable for the government to condition the availability of Medicaid funds on a recipient's agreement to reimburse Medicaid to the extent of a third party's liability. Therefore, according to HHS, "Medicaid has superior status to the recipient in relation to the tortfeasor to recover costs Medicaid incurred on behalf of the recipient on the condition that it would be reimbursed if there was a liable third party from whom a recovery was collected." *Wash. State Dep't*, D.A.B. No. 1561, at 8; *Calif. Dep't*, D.A.B. No. 1504, at 11. While the condition described may well be reasonable as a

matter of public policy, the HHS interpretation contradicts the express statutory language. Recipients are not required under federal law to reimburse Medicaid "to the extent of the third party's liability." *Id.* Rather, recipients are only required to assign their rights to third-party payments for medical care. 42 U.S.C. §§ 1396a(a)(25)(H), 1396k(a)(1)(A). We therefore reject HHS's second reason for requiring States to recover from third-party payments portions not designated for medical care.

Finally, HHS relied on a concern that if States were limited to recovering payments from third parties for medical care and services, then recipients could prevent state recovery by intentionally manipulating the amounts paid for various claims. *Wash. State Dep't*, D.A.B. No. 1561, at 9; *Calif. Dep't*, D.A.B. No. 1504, at 11. For example, during settlement negotiations, a Medicaid recipient could agree with a third party to reduce the amount paid for medical care, but increase the amount paid for pain and suffering. Or a recipient might attempt to recover only for damages other than past medical expenses, and thus assert that a lump-sum payment does not include funds for such expenses.

The federal statutes, of course, do not leave the States without a remedy in this situation: Through the assignment provision, a State has legal authority to pursue directly the third-party tortfeasor for medical expenses incurred by the recipient. And we do not foreclose the possibility that manipulation of settlement amounts might, in an appropriate case, provide the basis for a State to recover funds received by a Medicaid beneficiary from a third-party tortfeasor, even though they are not technically denominated payments for medical care and services. In such a circumstance, however, the recovery might be

permissible because the third-party payment is properly recharacterized *as a payment for medical expenses,* despite a different label applied by the parties, not because the federal statutes authorize the State to recover *all* payments from third parties up to the amount of funds expended by the state Medicaid program. In this case, there is no dispute about which portion of Ahlborn's settlement represents payment for medical care, so the potential for manipulation of settlements provides no basis for the State to capture funds received by Ahlborn to compensate for damages other than the costs of medical care.

In the end, we are left with a federal statutory scheme that clearly requires Ahlborn to assign her rights to recover from third parties for the costs of medical care and services incurred as a result of their tortious conduct, but protects all of Ahlborn's nonassigned property from recovery by the State through the anti-lien statute. The Arkansas statutes requiring Ahlborn to assign her entire cause of action against the third-party tortfeasors, and establishing a statutory lien on settlement proceeds for matters other than medical care and services, conflict with and frustrate this federal scheme. *See Hines v. Davidowitz,* 312 U.S. 52, 67, 61 S.Ct. 399, 85 L.Ed. 581 (1941). Accordingly, we conclude that Ahlborn prevails on the question of statutory construction presented by the parties on this appeal, and that the Arkansas assignment and recovery statutes are preempted to the extent that they require Ahlborn to assign her rights to recover third-party liability payments for matters other than the cost of her medical care and services.

* * *

The judgment of the district court is reversed, and the case is remanded with directions to enter judgment for the State in the amount of $35,581.47.

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280 F.Supp.2d 881

United States District Court,
E.D. Arkansas,
Western Division.
Heidi AHLBORN, Plaintiff,
v.
ARKANSAS DEPARTMENT OF HUMAN SERVICES; Kurt Knickrehm, Director of the Arkansas Department of Human Services; Wayne Olive, Director of the Third Party Liability Unit; Roy Jeffus, Interim Director, Division of Medical Services of the Arkansas Department of Human Services, Defendants.
No. 4:02-CV-00607 GTE.

Aug. 22, 2003.

H. David Blair, Blair & Stroud, Phillip B. Farris, Gregg & Harris, Batesville, AR, for plaintiff.

Richard B. Dahlgren, Arkansas Department of Human Services, Office of Chief Counsel, Little Rock, AR, for defendants.

ORDER GRANTING SUMMARY JUDGMENT

EISELE, District Judge.

This matter is before the Court on cross motions for summary judgment. The parties agree that the issue in this case – the extent to which Defendants are entitled to recoup Medicaid benefits paid on Plaintiff's behalf from settlement proceeds received by Plaintiff from her personal injury lawsuit – is a statutory construction issue for the Court. The parties have entered into a stipulation agreeing to the amount of reimbursement, depending on

which party prevails, making it unnecessary for the Court to hear evidence regarding damages or make any damage determinations in this case. (*See* Stipulation of Parties, docket entry 6).

The issue has been fully briefed. On August 20, 2003, the Court heard oral argument on the motions. After considering the written submissions of the parties and their oral presentations, the Court finds that Defendants are entitled to judgment as a matter of law.

I. *Facts Without Controversy*

Heidi Ahlborn suffered severe, permanently disabling injuries in a motor vehicle accident on January 2, 1996. Ms. Ahlborn filed suit against various individual and entity defendants alleged to be responsible for her injuries. Ms. Ahlborn sustained injuries and losses from the January 2, 1996 motor vehicle accident which would have given rise to the following elements of damage under Arkansas law:

(a) Permanent injury;

(b) Past and future medical expenses;

(c) Past and future pain, suffering and mental anguish;

(d) Past loss of earnings and working time;

(e) Permanent impairment of ability to earn in the future.

In 2002, a compromise settlement was reached with the alleged tort-feasors pursuant to which the sum of $550,000

was paid to Ms. Ahlborn.[1] The settlement amount represented a compromise of plaintiff's tort claim. No effort was made to allocate by agreement or adjudication the proceeds of the compromise settlement among the elements of damage arising under Arkansas law.

Following her accident, Plaintiff applied for and was granted Medicaid benefits to pay for her extensive medical treatment. The Medicaid program in Arkansas is funded with federal and state dollars and is administered by the Defendant Arkansas Department of Human Services ("ADHS"). ADHS provided Medicaid benefits to or on behalf of Plaintiff for medical care.

The Defendant Director of ADHS asserted a claim or lien pursuant to Ark.Code Ann. § 20-77-310, *et seq.*, in the amount of $219,156.78 against any settlement proceeds recovered by Plaintiff. That sum is being held by Plaintiffs' attorneys in a trust account pending resolution of this lawsuit, which was initiated on September 30, 2002, by Plaintiff Heidi Ahlborn. The Defendants are all state entities or officials with responsibilities related to the administration and enforcement of liens or rights by reason of payments made to or on behalf of Medicaid beneficiaries.[2]

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[1] Of that amount, $25,000 was paid by Plaintiff's underinsured motorist coverage.

[2] The amount of money paid on Ms. Alhborn's behalf as Medicaid benefits varies slightly in the pleadings, as she was still receiving benefits at the time of the settlement of her tort claims and the filing of this action. It is undisputed that Defendants had paid $216,645.20 in Medicaid proceeds at that time of the settlement of the third party action. However, Defendants are only seeking reimbursement in the sum of $215,645.30, if they prevail upon the statutory construction issue. The slight discrepancy in the numbers reflects adjustments made

(Continued on following page)

II. *Discussion*

The parties dispute the extent of Defendants' right of reimbursement from the settlement proceeds. Plaintiff contends the Defendants' Medicaid recovery is limited to that portion of the settlement proceeds which fairly represents the past medical expense component of her recovery. Defendants contend that they are entitled to a full reimbursement of all Medicaid funds paid on Plaintiff's behalf. The parties have stipulated to the respective damage amounts – if Plaintiff prevails, Defendants shall recover $35,581.47; if Defendants prevail, Defendants shall recover $215,645.30.

MEDICAID PROGRAM

The federal Medicaid statutes were enacted in 1965 as Title XIX of the Social Security Act, a publicly funded program to provide medical care to those lacking the resources to obtain essential medical services. 42 U.S.C.A. §§ 1396-1396v; *Norwest Bank of N.D., N.A v. Doth*, 159 F.3d 328, 331 (8th Cir.1998). Medicaid, which was intended to be the payor of last resort, is jointly funded by the federal and state governments. 42 C.F.R. § 430.0.

The federal government provides financial assistance to enable " . . . each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of [individuals], whose income and resources are insufficient to meet the costs of necessary medical services . . . " Participation in the program is voluntary, but

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to eliminate Medicaid payments made on Ms. Ahlborn's behalf for medical care unrelated to injuries sustained in the car accident.

once a state elects to participate, it must comply with the requirements set forth in the Medicaid Act and in regulations promulgated by the United States Secretary of Health and Human Services ("the Secretary") through the Centers for Medicare & Medicaid Services ("CMS") which administers Medicaid.[3] *See* 42 C.F.R. § 447.302. Participating states must submit for CMS's approval a state Medicaid plan. *See generally*, 42 U.S.C.A. § 1396a(a).

Arkansas participates in the federal Medicaid program and has designated Defendant ADHS as the single state agency responsible for administrating the State plan. *See* Ark.Code Ann. § 20-76-201(1). Arkansas' Medicaid plan, which the Secretary approved as consistent with the federal statute and implementing regulations, is codified at Ark.Code Ann. § 20-77-301 *et seq*.

Federal law requires that participating states include in their Medicaid plan the requirement that recipients of Medicaid funds assign to the state the right to receive payments for medical expenses from third parties liable for payment of those expenses. 42 U.S.C. § 1396k. The statute provides in pertinent part:

> (a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall –

[3] The federal agency responsible for administering Medicaid was formerly known as the Health Care Financing Administration, and frequently referred to as HCFA.

> (1) provide that, as a condition of eligibility for medical assistance under the State plan . . . the individual is required –
>
> (A) to assign to the States any rights, of the individual . . . to payment for medical care from any third party;
>
> . . . .
>
> (b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

Id.

In compliance with the federal requirement, Arkansas' plan provides ADHS with an automatic assignment of a Medicaid recipient's right of recovery from any settlement. The Arkansas statute reads:

> (a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.
>
> (b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.

> (c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

Ark.Code Ann. § 20-77-307.

Plaintiff argues the Arkansas statute assigns away more rights than required by 42 U.S.C. § 1396k(a), in conflict with a second provision of the federal Medicaid statute, 42 U.S.C. § 1396p(a)(1). This provision, often referred to as the "anti-lien provision", provides that

> [n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan . . . "[4]

Defendants contend that personal injury settlements assigned to the State in this context are not property of the individual beneficiaries of Medicaid assistance within the meaning of 42 U.S.C. § 1396p(a)(1). Their argument is based upon a reading of the "anti-lien" provision which makes it inapplicable to a Medicaid recipient's cause of action assigned away in exchange for Medicaid eligibility. Under this construction, although an injured party has a property right in her cause of action against a third party, the right is disposed of to the extent of medical expenses paid by Medicaid when she agrees, by virtue of the assignment, to apply *all* proceeds from a liable third-party to the state to the full extent of Medicaid benefits paid on her behalf. Thus, Defendants reason, a Medicaid recipient has no property interest in settlement funds from the third-party

[4] The statute contains two exceptions to the lien prohibition, but neither is applicable here.

until *after* the State and federal government have been reimbursed for their Medicaid expenditures.

Plaintiff's argument centers on the extent of the assignment. Plaintiff concedes that ADHS may force her to assign her tort claims to the extent of any amounts payable for medical expenses. She objects, however, to an assignment of her entire cause of action, contending that the federal scheme prohibits ADHS from attaching anything more than her claim for health care items or services from a third-party.

In support of her contention, Plaintiff relies on 42 U.S.C. § 1396a(a)(25)(H), which provides that:

> to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, *to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services*; . . .

(emphasis added).

The Plaintiff reasons that the State is only entitled to a statutory assignment of a Medicaid recipient's rights to third-party payments for "health care items or services," not for the entire cause of action, which may include damages for lost wages, pain and suffering and other non-healthcare related items. Construing the statute in such a fashion, Plaintiff argues, harmonizes the state procedure with 42 U.S.C. § 1396a(a)(25)(H) and § 1396p(a)(1). Construing the

statute otherwise, Plaintiff contends, permits the State to place a lien on Plaintiff's property in violation of the federal Medicaid Act's anti-lien provision.

ANALYSIS OF APPLICABLE LAW

In support of its position, Plaintiff relies upon the Minnesota Supreme Court's decision in *Martin v. City of Rochester*, 642 N.W.2d 1 (Minn.2002), *cert. denied*, 539 U.S. 957, 123 S.Ct. 2668, 156 L.Ed.2d 655, 71 U.S.L.W. 3116 (2003). This is the only decision, to the Court's knowledge, adopting the position advocated by Plaintiff. The *Martin* decision found Minnesota's state Medicaid subrogation provision[5] to be conflict preempted by the federal anti-lien provision to the extent that it permitted the state, through its assignment provision, to obtain anything more from a Medicaid recipient than the recipient's "rights to payment for medical care from third

[5] Minnesota's statutory assignment provision reads in pertinent part:

> To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person . . . from any third person liable for the costs of medical care for the person . . . The state agency shall require from any applicant or recipient of medical assistance the assignment of any rights to medical support and third party payments . . . . By signing an application for medical assistance, a person assigns to the department of human services all rights the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in . . . obtaining third party payments.

Minn.Stat. § 256B.056, subd. 6.

parties liable for the injuries that necessitated medical assistance." *Martin*, 642 N.W.2d at 18.

Central to the decision in *Martin* is the court's determination that §§ 1396k and 1396a(a)(25)(H) of the federal Medicaid statute limit the required assignment of rights to payment for medical care only. *Id.*, at 12-13. Thus, "a state's right to recover from third parties is specifically limited under federal law to payment *for health care items or services only.*" Starting with this premise, the *Martin* court concludes that the right assigned to states is likewise limited. *Id.*, at 13. The court summarizes its analysis as follows:

> The foregoing analysis convinces us that there is no need to engage in arduous or belabored statutory construction to harmonize the three federal statutes. Taking notice of the plain meaning of each is sufficient to achieve harmony.
>
> The anti-lien provision [§ 1398k)] protects the personal property of a medical assistance recipient – here, [Plaintiff's cause of action] – from a state's effort to recover for medical expenses. The assignment transfers to the state the recipient's right to recover medical expenses, and therefore the ability to pursue directly potentially liable third parties for medical assistance paid. The anti-lien provision protects all of a recipient's nonassigned rights to recover. The recovery provision [§ 1396a(a)(25)(H)] on the other hand, requires that the state pursue the third parties for medical expenses paid by the state, and the state does so under the assignment. The result is that the anti-lien provision operates in harmony with other federal Medicaid provisions and gives effect to all of the provisions.

Id., at 13.

The dissent in *Martin* concludes otherwise.

Focusing on the scope of the initial assignment, the dissent concludes that a state's assignment provision (requiring a recipient to apply or to agree to apply her settlement rights to the full extent of any Medicaid benefits paid on her behalf) poses no conflict with the federal anti-lien provision. *Martin*, 642 N.W.2d at 28-29 (dissent). The dissent in *Martin* and the highest courts of Utah and Washington reconcile any apparent conflict with § 1396p's anti-lien provision by finding that the anti-lien provision drops out of the analysis once a Medicaid recipient assigns his cause of action because the recipient no longer has any interest in the property (his or her cause of action against third parties) to the extent of the state's expenditures. *See Wallace v. Estate of Jackson*, 972 P.2d 446 (Utah 1998), *cert. denied, McNeil v. Utah, Medicaid Section*, 528 U.S. 810, 120 S.Ct. 42, 145 L.Ed.2d 38 (1999); and *Wilson v. State*, 142 Wash.2d 40, 10 P.3d 1061 (2000).

In *Wallace*, the Utah Supreme Court determined that a third party's payments do not legally become the property of the recipient until after settlement " 'because third party settlement proceeds have been specified by the recipient as belonging to the State Medicaid Agency as a precondition of the recipient's eligibility.' " *Id.*, 972 P.2d at 448 (quoting state's brief). Similarly, the Washington Supreme Court held in *Wilson* that all settlement proceeds belonged to the state because they were assigned as such. The Court found that "due to the lien being placed on the settlement prior to it becoming the property of the Medicaid recipient, the [anti-lien provision] is irrelevant." *Wilson*, 10 P.3d at 1065 n. 2. The court in *Wilson* specifically rejected limiting the permissible scope of a state's recovery from third-parties, finding that, "the state is not

limited to recovery from only that portion of the settlement specifically allocated to medical expenses. The federal statute states recovery is to the extent of payment made by the state for health care items or services." *Id.*, 10 P.3d at 1066.

The Eighth Circuit in *Norwest Bank of N.D., N.A. v. Doth*, 159 F.3d 328, 333-34 (8th Cir.1998), construing Minnesota's Medicaid statutes, held that the state could satisfy its lien from settlement proceeds before the funds were placed in a supplemental needs trust for the recipient. The *Doth* Court specifically noted that it was not passing "on the question of whether the lien [could] be satisfied out of the entire amount of the personal injury award or settlement, or only that portion of the settlement attributable to past medical expenses." *Id.*, 159 F.3d at 334.

The Secretary has consistently adopted the position urged by Defendants, taking the position that States must require, as a condition of eligibility, that recipients assign to the State their right to recover from third parties and that, from any such recovery, the State must recover the full amount of benefits paid on behalf of the recipient. *See* Defendants' Exh. 3, HCFA letter to State Agencies received June 13, 1988; Exh. 21 and 22, HCFA memorandums.

The Secretary has not hesitated to enforce its position against participating States, should they fail to recover from a Medicaid recipient subsequently acquired settlement proceeds up to the full amount of Medicaid benefits paid on the recipient's behalf. In such cases, to the extent a State allowed a Medicaid recipient to retain settlement proceeds without fully reimbursing the State, HCFA recoups from the State the federal share of such Medicaid

benefits. (*See* Exhibits 24 and 25 to Defendants' motion, Department of Health and Human Services Department Appeals Board decisions affirming the Secretary's decision to impose financial penalties on California and Washington for accepting less than a full recovery of Medicaid benefits paid).

The Court finds that the Secretary's position is entitled to due consideration. Cf. *United States v. Mead Corp.*, 533 U.S. 218, 121 S.Ct. 2164, 150 L.Ed.2d 292 (2001); *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512, 114 S.Ct. 2381, 129 L.Ed.2d 405 (1994) (reliance on Secretary's "significant expertise" particularly appropriate in the context of "a complex and highly technical regulatory program" (internal quotation marks omitted)); *Schweiker v. Gray Panthers*, 453 U.S. 34, 43-44, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981) (Secretary granted "exceptionally broad authority" under the Medicaid statute).

If, at the time Plaintiff applied for medical benefits, her lawsuit – which Plaintiff agrees is a property right – had been realized or reduced to a sum certain, she would have been forced to expend that resource before she would have qualified for Medicaid benefits. Thus, this is not – as Plaintiff argues – a situation in which Plaintiff's eligibility for Medicaid benefits is being determined retroactively after her tort claim is liquidated. Further, the Court disagrees with Plaintiff's contention that an unliquidated tort claim would not constitute a "resource" for purposes of determining an applicant's eligibility for Medicaid benefits.

In determining whether an applicant is eligible to receive Medicaid, Congress instructed states to consider an individual's income and resources. 42 U.S.C. § 1382.

Congress does not define "resources" affirmatively, but excludes from the definition of "resources" certain categories of property. 42 U.S.C. § 1382b. There is nothing in the language of the Act to exclude from the definition of "resources" an unliquidated tort claim against a third-party. Given the approach of the statute, which defines by exclusion, the Court finds that a Medicaid applicant's unliquidated tort claim against a third-party is both a "resource" and "property" for purposes of the Medicaid Act. Thus, there is nothing incongruent about requiring an applicant, as a condition of Medicaid eligibility, to assign to the State his entire "rights to payment from third parties." 42 U.S.C. § 1396k.

As stated by the Utah Supreme Court:

> Placing a lien against third party settlement proceeds does not result in a "lien against the property of an individual prior to his death on account of medical assistance paid or to be paid on his behalf" [which the anti-lien provision prohibits] because third party settlement proceeds have been specified by the recipient as belonging to the State Medicaid Agency as a precondition of the recipient's eligibility.

Wallace, 972 P.2d at 448 (referencing the State's brief).

Section 1396a(a)(25), which the Plaintiff construes as limiting Arkansas' right of assignment, is harmonized with the remainder of the Medicaid statute by a broader reading. The Medicaid statute requires States to ascertain the "legal liability" of third parties "to pay for care and services" rendered under the Medicaid program, 42 U.S.C. § 1396a(a)(25)(A), and, to pursue recovery to the full "*extent of such legal liability*," 42 U.S.C. § 1396a(a)(25)(B) (emphasis added). Full effect to the statute as a whole is

supported by an interpretation of the statutory provisions that does not limit States to the compromise value assigned to the medical expense component of the assigned claim during settlement negotiations. *See also* 42 U.S.C. § 1396k(a)(1)(A)(assigning right to "payment for medical care"); *Wilson*, 10 P.3d at 1066 ("[T]he assignment is for the right of payment from the third party, not solely the right to pursue a cause of action against the third party.").

Although the statutory language in question is far from a model of clarity, when the Court considers the statute as a whole, the Secretary's position on the issue, and the legislative history of the Medicaid statute,[6] it concludes that the Defendants have the better argument. The Medicaid statute is intended to vest States with the right to recover the full payment of medical expenses by a third party liable for causing the injuries which triggered the need for medical care.

As a public policy matter, the majority approach avoids the problem of determining what portion of a settlement is fairly attributable to payment for medical expenses. In this case, the parties have reached a stipulation on the apportionment issue. In general, however, adopting the approach advocated by Plaintiff would encourage manipulation of the allocation of settlement amounts. It would also place upon States the additional burden of proving up the past medical expense component of a compromise settlement or challenging the allocation

[6] Congress specifically "intended [Medicaid] to be the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S.Rep. No. 99-146, at 312 (1986), *reprinted in* 1986 U.S.C.C.A.N. 42, 279.

made by others with no interest in placing an appropriate value on that component of recovery. Conversely, the approach this Court adopts, which has been adopted by all but one court confronted with the issue, "prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care." *Martin*, 642 N.W.2d at 22 (internal quotes and citations omitted).

CONCLUSION

For the reasons discussed herein,

IT IS THEREFORE ORDERED that Plaintiff's Cross-Motion for Summary Judgment, Docket No. 14, be and it is hereby, DENIED.

IT IS FURTHER ORDERED that Defendant's Motion for Summary Judgment, Docket No. 7, be and it is hereby, GRANTED.

Judgment will be entered separately.

JUDGMENT

Pursuant to the Order filed in this matter this date granting summary judgment in favor of the Defendants, it is Considered, Ordered, and Adjudged that the Complaint in this matter be, and it hereby is, dismissed in its entirety.

42 U.S.C. § 1382b. Resources.

(a) Exclusions from Resources – In determining the resources of an individual (and his eligible spouse, if any) there shall be excluded –

(1) the home (including the land that appertains thereto);

(2)(A) household goods, personal effects, and an automobile, to the extent that their total value does not exceed such amount as the Commissioner of Social Security determines to be reasonable; and

(B) the value of any burial space or agreement (including any interest accumulated thereon) representing the purchase of a burial space (subject to such limits as to size or value as the Commissioner of Social Security may by regulation prescribe) held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family;

(3) other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Commissioner of Social Security, except that the Commissioner of Social Security shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee;

(4) such resources of an individual who is blind or disabled and who has a plan for achieving self-support approved by the Commissioner of Social Security, as may be necessary for the fulfillment of such plan;

(5) in the case of Natives of Alaska, shares of stock held in a Regional or a Village Corporation, during the period of twenty years in which such stock is inalienable, as provided in section 1606(h) and section 1607(c) of title 43;

(6) assistance referred to in section 1382a(b)(11) of this title for the 9-month period beginning on the date such funds are received (or for such longer period as the Commissioner of Social Security shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period); and, for purposes of this paragraph, the term "assistance" includes interest thereon which is excluded from income under section 1382a(b) (12) of this title;

(7) any amount received from the United States which is attributable to underpayments of benefits due for one or more prior months, under this subchapter or subchapter II of this chapter, to such individual (or spouse) or to any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this subchapter; but the application of this paragraph in the case of any such individual (and eligible spouse if any), with respect to any amount so received from the United States, shall be limited to the first 9 months following the month in which such amount is received, and written notice of this limitation shall be given to the recipient concurrently with the payment of such amount;

(8) the value of assistance referred to in section 1382a(b) (14) of this title, paid with respect to the dwelling unit occupied by such individual (or such individual and spouse);

(9) for the 9-month period beginning after the month in which received, any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime, to the extent that such individual (or such spouse) demonstrates that such amount was paid as compensation for expenses incurred or losses suffered as a result of a crime;

(10) for the 9-month period beginning after the month in which received, relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act (*42 U.S.C. § 4638*);

(11) for the 9-month period beginning after the month in which received –

(A) notwithstanding section 203 of the Economic Growth and Tax Relief Reconciliation Act of 2001, any refund of Federal income taxes made to such individual (or such spouse) under section *24* of the Internal Revenue Code of 1986 (relating to child tax credit) by reason of subsection (d) thereof; and

(B) any refund of Federal income taxes made to such individual (or such spouse) by reason of section *32* of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code (relating to advance payment of earned income credit);

(12) any account, including accrued interest or other earnings thereon, established and maintained in accordance with section 1383(a)(2)(F) of this title;

(13) any gift to, or for the benefit of, an individual who has not attained 18 years of age and who has a life-threatening condition, from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code –

(A) in the case of an in-kind gift, if the gift is not converted to cash; or

(B) in the case of a cash gift, only to the extent that the total amount excluded from the resources of the individual pursuant to this paragraph in the calendar year in which the gift is made does not exceed $2,000;

(14) for the 9-month period beginning after the month in which received, any amount received by such individual (or spouse) or any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this title as restitution for benefits under this title, title II, or title VIII that a representative payee of such individual (or spouse) or such other person under section 205(j), 807, or 1631(a)(2) has misused; and

(15) for the 9-month period beginning after the month in which received, any grant, scholarship, fellowship, or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational (including technical or vocational education) institution.

In determining the resources of an individual (or eligible spouse) an insurance policy shall be taken into account only to the extent of its cash surrender value;

except that if the total face value of all life insurance policies on any person is $1,500 or less, no part of the value of any such policy shall be taken into account.

* * *

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42 C.F.R. § 430.0 Program description.

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and state governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

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42 C.F.R. § 430.35 Withholding of payment for failure to comply with Federal requirements.

(a) Basis for withholding. CMS withholds payments to the State, in whole or in part, only if, after giving the agency reasonable notice and opportunity for a hearing in accordance with subpart D of this part, the Administrator finds

(1) That the plan no longer complies with the provisions of section 1902 of the Act; or

(2) That in the administration of the plan there is failure to comply substantially with any of those provisions.

* * *

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42 C.F.R. § 433.140 FFP and repayment of Federal share.

(a) FFP is not available in Medicaid payments if

(1) The agency failed to fulfill the requirements of §§ 433.138 and 433.139 with regard to establishing liability and seeking reimbursement from a third party;

* * *

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42 C.F.R. § 447.302 State plan requirements.

A State plan must provide that the requirements of this subpart are met.

***Ark. Code Ann. § 20-76-201.* Department of Human Services – Powers and duties.**

The Department of Human Services shall:

(1) Administer all forms of public assistance, supervise agencies and institutions caring for dependent or mentally or physically disabled or aged adults, and administer other welfare activities or services that may be vested in it;

* * *

Ark. Code Ann. § 20-77-301. Action by Department of Human Services.

(a) When medical assistance benefits are provided or will be provided to a medical assistance recipient because of injury, disease, or disability for which another person is liable, the appropriate division of the Department of Human Services shall have a right to recover from the person the cost of benefits so provided. The department may, to enforce the right, institute and prosecute legal proceedings against the third person who may be liable.

(b) No action taken on behalf of the division pursuant to this section or any judgment rendered in the action shall be a bar to any action upon the claim or cause of action of the recipient, his or her guardian, personal representative, estate, or survivors against the third person who may be liable for the injury. Nor shall any action operate to deny to the recipient the recovery for that portion of any damages not covered hereunder.

(c) The department shall likewise have the authority to recover the cost of benefits for medical care provided to indigent persons from third persons, whether or not the care was provided pursuant to the Arkansas Health Care Access Program, another program administered by the department, or a program administered through another department or agency of state government. The department shall remit to other departments or agencies of state government any amounts recovered, less its pro rata share and costs of collection, for care provided by them.

(d)(1) In actions in tort hereunder, no contributory or comparative fault of a recipient shall be attributed to the state, nor shall any restitution awarded to the state be

denied or reduced by any amount or percentage of fault attributed to a recipient.

(2) Notwithstanding subdivision (d)(1) of this section, if the recipient used a device, machine, or product after being warned, either verbally or in writing, that the use, misuse, or improper operation of the device, machine, or product was dangerous, risky, or could result in injury or harm to the recipient, then the statutory or common law defenses of contributory or comparative fault or negligence that could be asserted by the defendant against the recipient may also be asserted by the defendant in any action by the department or other agency of state government, and if the defenses are supported by the evidence, then recovery may be denied or reduced in the same manner as if the recipient were the plaintiff.

20-77-302. Action by recipient alone – Reimbursement of division.

(a) When an action or claim is brought by a medical assistance recipient or his or her legal representative against a third party who may be liable for injury, disease, disability, or death of a medical assistance recipient, any settlement, judgment, or award obtained is subject to the division's claim for reimbursement of the benefits provided to the recipient under the medical assistance program.

(b) In the event of judgment or award in a suit or claim against a third party, if the action or claim is prosecuted by the recipient alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses and attorney's fees. After the payment of these expenses and attorney's fees, the court or agency

shall order that the Department of Human Services receive an amount sufficient to reimburse the department the full amount of benefits paid on behalf of the recipient under the medical assistance program. The remainder shall be awarded to the medical assistance recipient.

20-77-303. Action by division and recipient.

(a) If an action is prosecuted both by the recipient and the division against a third person who is liable for injury, disease, or disability of the recipient, then in the event of judgment or award in a suit or claim against the third party, the court shall first order paid from any judgment or award the reasonable litigation expenses incurred in prosecution of the action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the recipient.

(b) After payment of expenses and attorney's fees, the court shall order that the division receive an amount sufficient to reimburse the division the full amount of benefits paid on behalf of the recipient under the medical assistance program.

(c) The remainder shall be awarded to the medical assistance recipient.

20-77-304. Notice of action or claim – Intervention or consolidation.

(a)(1) If either the medical assistance recipient or the division brings an action or claim against a third person, the recipient or Department of Human Services

shall, within thirty (30) days of filing the action, give to the other party written notice of the action or claim by personal service or registered mail.

(2) This notice shall contain the names of the third person and the court in which the action is brought.

(3) Proof of the notice shall be filed in the action.

(4) If an action or claim is brought by either the department or recipient, the other may, at any time before trial on the facts, become a party to the action or shall consolidate his or her action or claim with the other if brought independently.

(b) If the recipient, his or her guardian, personal representative, estate, or survivors bring an action against the third person who may be liable for injury, disease, or disability, then notice of institution of the legal proceedings and notice of settlement shall be given the Director of the Department of Human Services. All notices shall be given by the attorney retained to assert the recipient's claim, or by the recipient, his or her guardian, personal representative, estate, or survivors if no attorney is retained.

20-77-305. Notice to Department of Human Services of award or settlement by recipient required.

(a) No judgment, award, or settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease, or disability, in which the Department of Human Services has an interest, shall be satisfied without first giving the department notice and a reasonable opportunity to establish its interest.

(b) If a recipient, his or her guardian, attorney, or personal representative disposes of the funds that are to be held for the benefit of the department under this section without the written approval of the department, that person shall be liable to the department for any amount that, as a result of the disposition of the funds, is not recoverable by the department.

20-77-306. Liability of third parties to Department of Human Services.

All parties who were legally liable for any or part of any medical cost of an injury, disease, disability, or condition requiring medical treatment for which the Medicaid program, established by § 20-77-102 has paid, or has assumed liability to pay, shall be liable to the Department of Human Services for the amount of their liability to the extent that the department has paid or agreed to pay.

20-77-307. Assignment to Department of Human Services of rights of recovery.

(a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.

(b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.

(c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

(d) Every Medicaid applicant, as a condition of eligibility, shall cooperate in establishing paternity, except for good cause shown, for a child born out of wedlock for whom the recipient can legally assign rights, in obtaining medical care, support, and payments for himself or herself or any other person for whom the individual can legally assign rights, and in identifying and providing information to assist the department and the Office of Child Support Enforcement in pursuing any liable third party.

S. REP. 99-146
P.L. 99-272, COMPREHENSIVE OMNIBUS BUDGET . . .
SENATE REPORT NO. 99-146
October 2, 1985

5. Enhance Third-Party Liability Collections

Current law. – Medicaid is intended to be the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program.

Explanation of provision. – The provision would require the Secretary to issue regulations so that the States:

a. collect sufficient information to identify third party liabilities,

b. computer match information about the beneficiary with other data bases, as specified by the Secretary, and

c. use that information to pursue collections according to a plan approved by the Secretary of Health and Human Services.

The regulations would also provide that the States be financially penalized for not collecting the required information or not following through with the agreed-on collection plan. The provision would also make disclosure of third party liability a condition of eligibility for Medicaid. The provision clarifies the responsibility of Medicaid recipients for copayments and deductibles when third parties are liable for payments on their behalf. The provision would also clarify that Medicaid is the payer of last resort with respect to self-insured plans.

Effective date. – October 1, 1985.

DAB No. 1561 (1996)

Department of Health and Human Services (H.H.S.)
Departmental Appeals Board

Appellate Division

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Docket No. A-95-159
Control No. A-10-93-00017
Decision No. 1561
February 7, 1996

DECISION

The Washington State Department of Social and Health Services (Washington or State) appealed a determination by the Health Care Financing Administration (HCFA) disallowing $75,395 in federal financial participation (FFP) claimed under title XIX (Medicaid) of the Social Security Act (Act). The disallowance represents the federal share of amounts which HCFA determined Washington should have collected from third party liability (TPL) settlements and awards received by Medicaid recipients from June 1, 1992 through August 31, 1993. HCFA determined that these amounts should have been credited against the State's previous claims for its expenditures on behalf of these recipients.

Under Washington law, when the State provides medical assistance to a Medicaid recipient because of an injury for which a third party is liable, Washington is subrogated to the recipient's rights against the recovery from any liable party and has a lien to the extent of the value of the medical assistance provided. This lien is subject to reduction for a proportionate share of attorney's

fees, and may be compromised by the State. This disallowance was based on an audit by the Office of Inspector General (OIG) of ten judgmentally-selected casualty cases closed by the State. The OIG found that $137,032 ($75,395 in FFP) in available settlement monies were distributed by Washington to recipients rather than being retained for full reimbursement to the Medicaid program for its costs of medical assistance under the State's application of its compromise provision (five cases) or its attorney's fees provision (five cases). HCFA determined that, under the Act, HCFA must be fully reimbursed for the federal share before the recipient may receive any money from a TPL settlement or award. HCFA therefore disallowed the federal share of TPL payments that Washington allowed the recipients to retain.

The Board has previously addressed a similar state TPL recovery system in California Dept. of Health Services, DAB No. 1504 (1995) (California). In that decision, the Board concluded that the Act requires states to fully reimburse HCFA for the federal share of medical assistance expenditures resulting from the acts of a liable third party before allowing a recipient to receive money from a TPL settlement or award. HCFA contended that the Board's rationale in that case was controlling here. Washington maintained that its compromise system was materially different from California's, and that its system was consistent with Medicaid TPL requirements. Washington also contended that its attorney's fees provision properly allocated to Medicaid its share of the cost of recovery.

Below we set forth the relevant federal authority and Washington's statutory authority, and we summarize the California decision. We then analyze the parties' arguments in this case and determine that Washington's

compromise provision is inconsistent with the Act's TPL recovery provisions, but its attorney's fees provision is consistent. Accordingly, we conclude that the disallowance of the amounts related to the compromise cases should be upheld and the disallowance of the amounts related to attorney's fees should be reversed.

RELEVANT FEDERAL AUTHORITY

The Act requires a state to take "all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the [Medicaid state] plan. . . ." Section 1902(a)(25)(A). In cases where liability is found to exist after medical assistance is provided, "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." Section 1902(a)(25)(B). A state is not required to seek such reimbursement if "the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery. . . ." *Id.*

Applicants for Medicaid are required to assign to the state their rights to "payment for medical care from any third party" and to cooperate with the state's pursuit of third party payment. Section 1912(a). The amount collected under such an assignment –

shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual. Section 1912(b).

Legitimate costs of obtaining the settlement or award, such as attorney's fees, may be deducted prior to reimbursement of the Medicaid program. HCFA's State Medicaid Manual (SMM) § 3907, HCFA Exhibit (ex.) A.

RELEVANT WASHINGTON STATUTORY AUTHORITY

Under Washington state law, if Washington provides Medicaid benefits to a recipient because of an injury or illness for which a third party tortfeasor may be liable, the State is subrogated to the recipient's rights against the tortfeasor or the tortfeasor's insurer, or both, and has a lien to the extent of the value of the Medicaid benefits provided. Wash. Rev. Code § 74.09.180.[1] This lien is "upon any claim, right of action, settlement proceeds, money or benefits arising from an insurance program to which the recipient might be entitled. . . ." Wash. Rev. Code § 43.20B.060(3).[2] The lien is subject to Wash. Rev. Code

[1] RCW 74.09.180 reads – Chapter does not apply where another party liable – Exception – Subrogation – Lien – Reimbursement. The provisions of this chapter shall not apply to recipients whose personal injuries are occasioned by negligence or wrong of another: PROVIDED, HOWEVER, That the secretary may furnish assistance, under the provisions of this chapter, for the results of injuries to or illness of a recipient, and the department shall thereby be subrogated to the recipient's rights against the recovery had from any tort feasor or the tort feasor's insurer, or both, and shall have a lien thereupon to the extent of the value of the assistance furnished by the department. To secure reimbursement for assistance provided under this section, the department may pursue its remedies under RCW 43.20B.060.

[2] RCW 43.20B.060 provides, in pertinent part –

> Reimbursement for medical care or residential care – Lien – Subrogation. (1) To secure reimbursement of any assistance paid under chapter 74.09 RCW or reimbursement for any residential care provided by the department at a hospital for the mentally ill or habilitative care center for

(Continued on following page)

§ 43.20B.050(1), referred to by the OIG as Washington's compromise provision, which provides that:

> No settlement made by and between the recipient and tort feasor and/or insurer shall discharge or otherwise compromise the lien created in RCW 43.20B.060 without the express written consent of the secretary [of Social and Health Services] . . . or the secretary's designee. Discretion to compromise such liens rests solely with the secretary or the secretary's designee.

The lien is also subject to Washington's attorney's fees provision:

> If recovery is made by the department under this section and the subrogation is fully or partially satisfied through an action brought by or on behalf of the recipient, the amount paid to the

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> the developmentally disabled, as a result of injuries to or illness of a recipient caused by the negligence or wrong of another, the department shall be subrogated to the recipient's rights against the tort feasor or the tort feasor's insurer, or both. (2) The department shall have a lien upon any recovery by or on behalf of the recipient from such tort feasor or the tort feasor's insurer, or both to the extent of the value of the assistance paid or residential care provided by the department, ...
>
> . . .
>
> (3) The lien of the department shall be upon any claim, right of action, settlement proceeds, money, or benefits arising from an insurance program to which the recipient might be entitled (a) against the tort feasor or insurer of the tort feasor, or both, and (b) under any contract of insurance purchased by the recipient or by any other person providing coverage for the illness or injuries for which the assistance or residential care is paid or provided by the department.

> department shall bear its proportionate share of attorneys' fees and costs.

Wash Rev. Code § 43.20B.060(4).[3]

The State provided an affidavit from the chief of the unit responsible for TPL recoveries explaining how these statutory provisions are implemented. *See* State ex. 12. She stated that, in casualty cases where a third party tortfeasor is alleged to be liable, the State initially asserts a lien in the full amount of medical expenses related to the injuries. The unit later makes a case-by-case analysis of each settlement. Washington may reduce the amount of the lien to less than Medicaid expenditures when the settlement amount is not sufficient to pay all medical expenses and other types of damages. *Id.* at 2. The unit

[3] RCW 43.20B.060(4) further provides –

> The determination of the proportionate share to be borne by the department shall be based upon: (a) The fees and costs approved by the court in which the action was initiated; or (b) The written agreement between the attorney and client which establishes fees and costs when fees and costs are not addressed by the court. (c) When fees and costs have been approved by a court, after notice to the department, the department shall have the right to be heard on the matter of attorneys' fees and costs or its proportionate share. (d) When fees and costs have not been addressed by the court, the department shall receive at the time of settlement a copy of the written agreement between the attorney and client which establishes fees and costs and may request and examine documentation of fees and costs associated with the case. The department may bring an action in superior court to void a settlement if it believes the attorneys' calculation of its proportionate share of fees and costs is inconsistent with the written agreement between the attorney and client which establishes fees and costs or if the fees and costs associated with the case are exorbitant in relation to cases of a similar nature.

determines the reduction of the lien for attorney's fees and costs by taking the total lien amount divided by the total settlement amount to obtain the percentage the State will allow of the attorney's fees and costs as a deduction from the lien amount. *Id.* at 2-3.

THE CALIFORNIA DECISION

In California, HCFA disallowed the federal share of TPL payments that California allowed recipients to retain even though Medicaid was not fully reimbursed. The Board upheld HCFA's position that the Act requires states to fully reimburse HCFA for the federal share of medical assistance expenditures resulting from the acts of a liable third party before allowing a recipient to receive money from a TPL settlement or award. Specifically, the Board found that three provisions of the Act supported this result:

> . Section 1912(a)(1)(A), which requires all recipients to execute an assignment of rights "to payment for medical care from any third party;"
>
> . Section 1902(a)(25)(B), which requires states to seek TPL reimbursement to the extent of a third party's liability; and
>
> . Section 1912(b), which provides that any amount a state collects under a recipient's assignment to payment for medical care must be used first to reimburse the Medicaid program for medical assistance payments and that the recipient is entitled only to the remainder.

The Board determined that HCFA's position was directly supported by these provisions of the Act. Recipients, as a condition of eligibility, must assign their rights

to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to the recipient. While section 1912(a) refers to assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.

The Board determined further that HCFA's position is also consistent with the purposes behind Medicaid TPL requirements: to make Medicaid the payor of last resort where there is a liable third party, so as to reduce Medicaid expenditures. In 1985, when Congress amended the Act to strengthen TPL recovery requirements, the accompanying legislative history provided: "Medicaid is intended to be the payor of last resort; that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." Consolidated Omnibus Budget Reconciliation Act of 1985, H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 542 (1985), reprinted in Legislative History of Titles I-XX of the Social Security Act, Vol. XXII, 99th Congress 1985-1986, Part 1. DAB No. 1504, at 7. The Board found that the language clearly indicates that Congress intended for the Medicaid program to be reimbursed from available third party sources to the fullest extent possible.

The Board noted that it had repeatedly held that it will not substitute its judgment for, or overturn, a reasonable interpretation of the agency charged with administering

a statute merely because there may be an alternative interpretation which arguably is also permissible. DAB No. 1504, at 8, citing Georgia Dept. of Human Resources, DAB No. 995 (1988); Missouri Dept. of Social Services, DAB No. 468 (1983).

ANALYSIS

Washington argued that HCFA had misapplied the Act, that Washington's TPL process was distinguishable from California's, and that HCFA had approved Washington's TPL process or alternatively, had failed to give it adequate notice that the process violated the Act. In the first section of analysis we discuss Washington's arguments and explain why we conclude that HCFA is entitled to impose a disallowance as to the compromise cases. In the second section of the analysis we discuss Washington's attorney's fees provision and why the disallowance of costs for payment of attorney's fees should be reversed.

A. The Compromise Provision

1. Whether a state must assert a priority over the recipient's casualty award to the full extent of the state's expenses

Washington argued there was no legal basis in the Act for HCFA's insistence that a recipient "transfer ownership to the state of an entire tort settlement that is insufficient to compensate the recipient for medical and other injuries for which the tortfeasor is liable" or for HCFA's insistence that recipient's assignment of medical damages gives a state a priority over the award to the extent of its costs. Washington Opening Brief (Br.) at 6-7. Washington relied on section 1912(a), which requires a Medicaid recipient to

assign his or her rights to payment for medical support and other medical care; on section 1902(a)(25)(A), which requires a state to take reasonable measures to ascertain the legal liability of third parties to pay for Medicaid care and services; and on section 1912(b), which sets forth the priority for distribution of the amount "collected by the State under an assignment."

The Board dealt with these arguments in California. Below, we restate our reasoning in that case.

First, HCFA has not taken the position that a recipient assigns or loses his/her right to seek compensation for injuries beyond the cost of medical care, nor does HCFA assume that the recipient's recovery represents only payment for medical care. Rather, HCFA's position is that, where there is a third party that is responsible for paying a recipient's medical expenses, the recipient may not recover money for him/herself until the federal government is reimbursed for its expenditures for the recipient's medical care.

Second, for the following reasons, HCFA may require a state to assert a collection priority over funds obtained by Medicaid recipients in TPL suits even though the distribution methodology set forth in section 1912(b) refers only to payments collected pursuant to assignments for medical care.

> . In cases where a third party has caused the need for medical care and is liable for its payment, the Act looks to that third party to reimburse the public. Section 1902(a)(25)(B) requires that "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." HCFA reasonably construed this provision to require states to pursue the full claim against a third party.
>
> . HCFA reasonably read the Act to condition the availability of Medicaid funds on the recipient's agreement to reimburse Medicaid to the extent of a third party's liability. Therefore, Medicaid has superior status to the recipient in relation to the tortfeasor to recover costs Medicaid incurred on behalf of the recipient on the condition that it would be reimbursed if there was a liable third party from whom a recovery was collected.
>
> . HCFA has reasonably insisted on its right to characterize recoveries from third parties first as payments for medical care. This characterization prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care (e.g., by suing for pain and suffering or lost wages rather than for medical costs). Without it, TPL recoveries would be subject to a wide range of interpretations about what was appropriately considered payment for medical care.

Therefore, we reject Washington's position that HCFA has misinterpreted the meaning of sections 1902(a)(25)(A) and 1912(a) and (b) of the Act.

2. Whether Washington's TPL system is distinguishable from California's TPL system

Washington argued that its TPL program was distinguishable from California's because, rather than reserving a statutorily set percentage recovery for Medicaid recipients, Washington reviews the circumstances in each individual settlement. According to Washington, it only

approves a compromise which would allow the Medicaid recipient to retain a portion of a settlement when it determines that recovery to the State would be less if it forced the recipient to litigate the question of liability. Washington stated that its goal "in every case is to maximize reimbursement to the Medicaid program" and that "[a] reduction in the State's recovery from a settlement or judgment is only considered when the settlement amount is not sufficient to pay all [medical and non-medical] expenses." Washington Br. at 5.

We do not find Washington's system different from California's in any material way. While Washington asserted that its case-by-case determinations maximize its TPL recoveries, California made similar claims about its system. DAB No. 1504, at 13. Therefore, even though California's system relied on a formula for determining the amount of its recovery, the reason California professed to use the formula (maximizing TPL recoveries) and the result of California's system were the same as in Washington. Under both systems, Medicaid recipients were allowed to retain portions of casualty awards even though the Medicaid program had not been reimbursed to the full extent of its participation in the recipient's costs.

3. Whether HCFA approved Washington's TPL system or failed to give it adequate notice that its TPL system was contrary to the Act

Washington also asserted that HCFA approved Washington's Medicaid state plan with "full knowledge and understanding of the manner and methods employed in casualty recoveries, including compromises, settlement, and attorney fee sharing." Washington Br. at 2. Washington concluded that HCFA should be estopped from imposing this

disallowance given its alleged approval of Washington's practices. *Id.* at 6. We note initially that it is not clear that estoppel will ever lie against the federal government, *Office of Personnel Management v. Richmond*, 496 U.S. 414, 423-34 (1990), and if available at all, is probably not available absent affirmative misconduct by the federal government. *Schweiker v. Hansen*, 450 U.S. 785 (1981); *see also Wisconsin Dept. of Health and Social Services*, DAB No. 1493 (1994). But even if estoppel could lie against HCFA, Washington did not prove the elements of estoppel in this case. A party seeking to assert estoppel must prove that: 1) the party against whom estoppel is sought made false representations; 2) the party claiming estoppel relied on the false representations to the party's detriment; and 3) the reliance was reasonable, in that the party claiming the estoppel neither knew nor should have known that its adversary's conduct was misleading. *Heckler v. Community Health Services*, 467 U.S. 51, 59 (1984). Further, erroneous oral advice is inadequate, as a matter of law, to estop the government from enforcing federal law. *Heckler v. Community Health Services*, 467 U.S. at 65; *see also Wisconsin* at 15. The Supreme Court reasoned in the Community Health Services case:

> The necessity for ensuring that governmental agents stay within the lawful scope of their authority, and that those who seek public funds act with scrupulous exactitude, argues strongly for the conclusion that an estoppel cannot be erected on the basis of the oral advice that underlay respondent's cost reports. That is especially true when a complex program such as Medicare is involved, in which the need for written records is manifest.

467 U.S. at 65.

For the following reasons, Washington has failed to establish that any HCFA official represented to the State in writing that its TPL compromise practice was consistent with the Act.

. Washington argued that by approving its Medicaid state plan, HCFA approved its TPL practices. Washington Br. at 2. However, the provisions of Washington's Medicaid state plan submitted by the State as Exhibit 1 comport with the Act's statutory scheme on their face and do not even allude to Washington's compromise policy. *See* State ex. 1. Thus, we disagree that HCFA's approval of the state plan provisions somehow equates to HCFA's ratification of the State's practice of compromising TPL recovery on a case-by-case basis.

. Washington also provided an affidavit of a senior program manager of its state TPL system. State ex. 11. That manager claims that HCFA's approval of the Washington State Medicaid plan "was done with full knowledge and understanding of the manner and methods employed in casualty recoveries, including compromises, settlements and attorney fee sharing by the State of Washington. In addition, prior interpretations of policy and law, also provided through HCFA, affirmed the aforementioned as consistent with acceptable practices." State ex. 11 at 2. This affidavit is unpersuasive because it does not identify the manner in which HCFA obtained knowledge of Washington's system, nor specifically assert that HCFA was informed, prior to the OIG audit, that the State was actually allowing Medicaid recipients to retain part of the recovery before Medicaid was reimbursed in situations where this reduced reimbursement of the federal

share of medical assistance. The affidavit also does not identify to which "prior interpretations of policy and law, also provided by HCFA, . . ." the affiant is referring.

. Moreover, HCFA presented an affidavit of a HCFA reviewer that stated that his office informed Washington in 1989 that it should ensure that all possible TPL monies were recovered "in accordance with Federal Regulations which makes [sic] provisions for only the payment of reasonable attorney fees and court costs." HCFA ex. B at 13. Included as an attachment to the affidavits is a 1989 letter from the Associate Regional Administrator, HCFA, directing Washington to submit a corrective action plan.

Washington also contended that it did not have adequate notice that HCFA considered its TPL system to be contrary to the Act. We do not find this contention persuasive. As noted above, HCFA asserted that it informed Washington in 1989 in the course of a program review that it should modify its TPL procedures. Further, in 1990, HCFA amended the State Medicaid Manual (SMM) to provide that "[i]n liability situations, the Medicaid program must be fully reimbursed before the recipient can receive any money from the settlement or award." SMM § 3907.[4] This revision put Washington on notice that a compromise of individual settlements permitting a recipient to keep settlement money before the Medicaid program was fully reimbursed was contrary to HCFA's interpretation of the requirements of the Act.

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[4] Amendments to the SMM are routinely provided to states, and Washington did not deny receiving the amendment in a timely manner.

Thus, Washington's contentions that it did not have notice of HCFA's interpretation of the TPL provisions of the Act and that HCFA should be estopped from taking this disallowance fail. Moreover, in light of our conclusion that Washington was on notice of HCFA's interpretation of the Act's TPL provisions, Washington's argument that HCFA should now be prevented from applying its interpretation of the Act "retroactively" also fails.

4. Whether Washington exercised its compromise authority consistent with federal regulations

Washington argued that it exercised its compromise authority pursuant to 42 C.F.R. § 433.139(f), which grants states a measure of discretion in deciding when to pursue third party reimbursement. Washington explained that in each of the disallowed compromise cases the amount of the settlement was not sufficient to compensate the recipient both for the damages suffered for medical injuries, which were assigned to the State, and for other damages to the recipient like wage loss and pain and suffering.[5] Washington Br. at 8. It represented that if it had not compromised its claim, the cases would not have settled and the State would have assumed the risk of an even greater reduction to its claim resulting from an adverse judgment or an unfavorable judicial apportionment of damages. Washington Br. at 9. Therefore, Washington argued, its decision to compromise these claims was within the discretion

[5] For example, in case number 1, the Medicaid payment was $204,055, while the total settlement available was $35,000. In case number 2, the Medicaid payment was $28,320 and the total settlement was $25,000.

granted to it by 42 C.F.R. § 433.139(f). That section provides:

> (1) An agency must seek reimbursement from a liable third party on all claims for which it determines that the amount it reasonably expects to recover will be greater than the cost of recovery. Recovery efforts may be suspended or terminated only if they are not cost effective.
>
> (2) The State plan must specify the threshold amount or other guideline that the agency uses in determining whether to seek recovery of reimbursement from a liable third party, or describe the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
>
> (3) The State plan must also specify the dollar amount or period of time for which it will accumulate billings with respect to a particular liable third party in making the decision whether to seek recovery of reimbursement.

The State plan provisions submitted by Washington in this case provide for a threshold amount of $20.00. State ex. 1 at sixth unnumbered page ("Attachment 4.22-B"). Washington's statutory compromise provisions are not referenced. The State's TPL recovery unit chief stated that, in the cases involved here –

> it was determined, after investigation of the relevant facts and circumstances and discussions with the attorneys involved, that the cost to the Department would be less to compromise the claim, allowing the client to retain some funds, than to force a lawsuit against the responsible party. The costs plus the probability of a defense

verdict made it a prudent decision to compromise the Department's lien.

State ex. 12, at 2.

Section 433.139(f) does not give Washington the discretion to allow a recipient to retain funds that are due Medicaid. Rather, it requires the State to set forth in its State plan how it determines that the amount it reasonably expects to recover will be greater than the cost of recovery. Here, the State did not set forth the guidelines it uses in determining that pursuit of reimbursement in a particular case is not cost-effective, either in its state plan or in the affidavit of its TPL recovery unit chief. Instead, Washington relied upon its own subjective policy determination that permitting compromise of its liens will maximize TPL recoveries.

We note that California also argued that its system was in full compliance with federal law and regulations on the grounds that it "balance[d] expectant costs with the potential recovery." California at 13. Specifically, California argued that, by allowing victims to share in awards, it created an incentive to seek out and pursue liable third parties, thereby maximizing pursuit and shifting initial costs from California to the victim, and that its program was cost effective.

As in California, we do not find arguments concerning the cost-benefit aspects of Washington's TPL system persuasive for the following reasons:

. The alleged effectiveness of Washington's statutory scheme is not the criterion by which we must evaluate this disallowance. Rather, we must apply the Act, as reasonably interpreted by HCFA. We have explained why, under that criterion, Washington's system does not comply with federal law.

. The role of evaluating the practical considerations that Washington advanced in support of its system belongs to HCFA, not the Board. As the administering agency, HCFA has the expertise and knowledge to weigh the benefits of Washington's system against the adverse effects of such a system on the operation of the Medicaid program. Moreover, half of the Medicaid funds the State is allowing the victim to keep came from the federal treasury. Consequently, HCFA is the entity which is logically charged with the responsibility of deciding what constitutes a fair balance for this aspect of the Medicaid program. To allow the many jurisdictions which participate in the Medicaid program the discretion to set that balance for third party casualty claims could undermine the TPL system and lead to divergent treatment of similarly situated recipients. Further, as HCFA has said previously, a state is free to allow recipients to retain the state's share of the recovery if the state believes that is an equitable result. California at 14.

. While Washington maintained that its compromise practice was necessary to make its TPL recovery system work, HCFA could reasonably conclude otherwise. For example, even if Washington asserted a complete priority over the recoveries, private attorneys would continue to have a financial incentive to take these cases because they would continue to be compensated first. Further, recipients are obligated under section 1912(a)(1)(C) of the Act to cooperate with Washington's pursuit of third party payment as a condition of eligibility, regardless of whether they retain any third party payment.

. It is not unfair to completely or substantially deny Medicaid recipients access to their settlements. If Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements. As Medicaid recipients, they do not have such debts because the public has paid their medical expenses. Therefore, in cases where Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.

In summary, HCFA has the authority and the expertise to interpret the Act and to evaluate the practical considerations involved with seeking third party reimbursement from personal injury settlements and awards. In this case, HCFA has reasonably interpreted the Act to preclude systems which allow recipients to retain TPL payments from which the federal share of Medicaid expenditures has not been deducted. For the preceding reasons, we uphold the disallowance of the amounts associated with the five cases in which Washington applied its compromise provision to permit recipients to receive moneys due Medicaid.

B. The Attorney's Fees Provision

Washington contended that its method of calculating attorney's fees properly allocated to Medicaid its appropriate share of the cost of recovery. Washington maintained that the OIG's method imposed all of these costs on the recipient.

Washington offered the following example of how the two systems operated:

Assume a $10,000 settlement where attorney's fees (and costs) were $3,000 and Medicaid's outlay for medical expenses was $5,000.

OIG's Method

$10,000	settlement amt.
- 3,000	attorney's fees
7,000	
- 5,000	Medicaid outlay
$ 2,000	recipient's recovery

Washington's Method

$ 5,000 / $10,000	Medicaid outlay / settlement amount	= 50% Medicaid's share of recovery costs
50% ($3,000)	Medicaid's atty's fees % of recovery costs	= $1,500 Medicaid's share of recovery costs

$10,000	settlement amt.
- 1,500	Medicaid's share of recovery costs
- 5,000	Medicaid's outlay
$ 3,500	recipients recovery

Under the OIG's method, both the attorney's fees and Medicaid's share are deducted before the recipient shares in the recovery. According to Washington, this example shows that the OIG's method results in Medicaid bearing none of the costs of recovery. Under Washington's method, Medicaid is assessed a share of the attorney's fees proportionate with its share of the settlement proceeds – one-half, in the example displayed above – and the recipient also pays his or her proportionate share of the costs of recovery. Washington contended that its method fairly

allocates the costs between the recipient and Medicaid, and comports with SMM § 3907, cited by HCFA, which states, "Legitimate costs of obtaining the settlement or award, such as attorney fees, may be deducted prior to reimbursement to the Medicaid program."

We conclude that Washington's proportional assessment of attorney's fees against the Medicaid program is appropriate. Washington's assessment of attorney's fees is consistent with SMM § 3907, which authorizes deduction of attorney's fees prior to reimbursement of the Medicaid program.[6] The OIG method used in this case results in Medicaid bearing none of the legitimate costs of obtaining the settlement and is patently unfair. Moreover, we note that in the California case, California used, without objection from the OIG, a method of deducting attorney's fees from the settlements similar to Washington's.

HCFA's only response to Washington's contention was that the allegedly unfair result was due to the State relying on private attorneys rather than going after the TPL amount itself, and that Washington cannot abrogate its responsibility in this manner. HCFA's response to Washington's arguments was not persuasive for at least two reasons. First, nothing in the Act or regulations indicates that reliance on private attorneys for pursuit of third party recoveries is impermissible. Second, if the State pursued TPL recovery itself, the same problem would result: the Medicaid program would incur costs for the work of attorneys.

[6] We note that Washington has included provisions in its statute which prevent attorney's fees from being manipulated to impose on the State more than its fair share of a reasonable fee. *See* text of footnote 3.

Based on the reasons above, we reverse the portion of the disallowance relating to apportionment of attorney's fees.

CONCLUSION

Based on the above analysis, we uphold HCFA's disallowance of $69,687 FFP for Washington's compromise cases and reverse HCFA's disallowance of $5,708 for Washington's attorney's fees cases.[7]

Judith A. Ballard

Cecilia Sparks Ford

M. Terry Johnson

Presiding Board Member

[7] In its disallowance letter, HCFA instructed Washington to "recalculate the distribution of settlements and awards made after August 31, 1993, where your department has applied the state's compromise and attorney fees provisions to casualty cases" and to "make a decreasing adjustment in the amount determined that should have been retained by your department to fully reimburse Medicaid." Disallowance Letter of June 9, 1995, at 4. In its Notice of Appeal, Washington referred to this "recalculated amount" as being in dispute in this case. Notice of Appeal at 1. In its Reply Brief, Washington argued that, since HCFA's brief had addressed only the $75,395 disallowance, the Board should find that HCFA has acquiesced to the State's position on the issue of recalculation of settlements after August 31, 1993. Reply Brief at 2. To the contrary, it is clear from HCFA's brief that it did not acquiesce to Washington's position that its settlement policy was permissible so that no decreasing adjustment is needed. Consequently, HCFA's direction stands; the effect of this decision, however, is that the State need not recalculate recoveries of attorney's fees. Washington may appeal any future disallowances resulting from its recalculation.

DAB No. 1504 (1995)

Department of Health and Human Services (H.H.S.)
Departmental Appeals Board

Appellate Division

CALIFORNIA DEPARTMENT OF HEALTH SERVICES
Docket No. A-94-114
Control No. A-09-92-00095
Decision No. 1504
January 5, 1995

DECISION

The California Department of Health Services (California or State) appealed a determination by the Health Care Financing Administration (HCFA) disallowing $7,592,786 in federal financial participation (FFP) claimed under title XIX (Medicaid) of the Social Security Act (Act). The disallowance represents the federal share of amounts which HCFA determined California should have collected from third party liability (TPL) settlements and awards received by Medicaid recipients from July 1, 1988 through June 30, 1992. HCFA determined that these amounts should have been credited against California's previous claims for its expenditures on behalf of these recipients.

Under California law, when California provides medical benefits to a Medi-Cal (California's name for Medicaid) recipient because of an injury for which a third party is liable, California is entitled to recover the reasonable value of the benefits from that third party. This case arose because California did not fully recover, from TPL settlements and awards obtained by Medi-Cal recipients, reimbursement for the reasonable value of the Medi-Cal benefits it provided; instead, California allowed recipients

to retain at least 50% of the settlement or award. HCFA determined that, under the Act, HCFA must be fully reimbursed for the federal share before the recipient may receive any money from a TPL settlement or award. HCFA therefore disallowed the federal share of TPL payments that California allowed the recipients to retain.

California appealed this disallowance on the ground that HCFA had no authority under the Act to prohibit states from allowing recipients to retain portions of TPL payments which did not represent payment for medical care. California further argued that its TPL recovery program was highly successful and furthered federal TPL requirements by maximizing TPL recoveries while reducing TPL associated administrative expenses.

Based on our review of the evidence and argument in the record, and the relevant provisions of the Act, we conclude that HCFA's interpretation of the Act is a reasonable construction of its express terms and is supported by the legislative history. Further, California has had notice of HCFA's interpretation of these TPL provisions since 1988. Accordingly, we uphold the disallowance.

Relevant Federal Authority

The Act requires a state to take "all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the [Medicaid] plan. . . ." Section 1902(a)(25)(A). In cases where liability is found to exist after medical assistance is provided, "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." Section 1902(a)(25)(B). A state is not required to seek such reimbursement if "the

amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery. . . ." *Id.*

Applicants for Medicaid are required to assign to the state their rights to "payment for medical care from any third party" and to cooperate with the state's pursuit of third party payment. Section 1912(a). The amount collected under such an assignment –

> shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

Section 1912(b).

Legitimate costs of obtaining the settlement or award, such as attorney's fees, may be deducted prior to reimbursement of the Medicaid program. HCFA's State Medicaid Manual (SMM) § 3907, HCFA Exhibit (Ex.) A.

Relevant California Statutory Authority

Under California law, if California provides Medi-Cal benefits to a recipient because of an injury for which a third party is liable, California is entitled to recover, from that third party, the reasonable value of the benefits it provided. Cal. Welf. & Inst. Code § 14124.71(a).

California has enacted a statutory scheme to effectuate such TPL recoveries from tortfeasors and their insurers. Cal. Welf. & Inst. Code §§ 14124.70-14124.90. Under

California's scheme, any settlement, judgment, or award obtained by a recipient is subject to California's claim for reimbursement of the Medi-Cal benefits. Cal. Welf. & Inst. Code § 14123.74. If a representative of a Medi-Cal recipient or the recipient brings an action against a third party who may be liable for an injury which has resulted in Medi-Cal expenditures, he or she must provide notice of the action to California. Cal. Welf. & Inst. Code § 14124.79. This notice enables California to perfect a lien upon any judgment or settlement that the recipient obtains from the third party. Cal. Welf. & Inst. Code §§ 14124.76, 14124.77. Further, after payment of the litigation costs and attorney's fees, California's lien is given priority in the distribution of any judgment or award obtained by the victim. Cal. Welf. & Inst. Code § 14124.74.

Under California's statutory scheme, any recovery by the Medi-Cal recipient is distributed pursuant to one of three alternative methods:

> o The 25% method. California Welfare and Institutions Code section 14124.72(d) provides that, where the action is brought by the victim (without California) and the victim incurs a personal liability to pay attorney's fees and costs of litigation, California's claim for reimbursement is limited to the amount of California's Medi-Cal expenditures, less a portion of the costs of litigation and 25% for attorney's fees.[1]

[1] Section 14124.72(d) provides:

> Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the director's claim for reimbursement of the benefits provided to the beneficiary

(Continued on following page)

o The 50% method. California Welfare and Institutions Code section 14124.78 limits California's claim to not more than one half of the recipient's recovery after deducting for attorney's fees, litigation costs and medical expenses paid for by the recipient relating to the injury.[2]

o The waiver method. California Welfare and Institutions Code section 14124.71(b) allows California to waive part or all its claim on the lien and take less than it would be entitled to under the 25% or 50% method if it determines that waiver is appropriate.[3]

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shall be limited to the amount of the medical expenditures for the benefit of the beneficiary less 25 percent which represents the director's reasonable share of attorney's fees paid by the beneficiary and that portion of the cost of litigation expenses determined by multiplying the ratio of the full amount of expenditures to the full amount of the judgment, award or settlement.

[2] Section 14124.78 provides:

> Except as otherwise provided in this article, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to . . . [California's] claim for reimbursement of the benefits provided and any lien filed pursuant thereto, but in no event shall [California's] claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury paid by the beneficiary.

[3] Section 14124.71(b) provides:

The director may: * * *

> (2) Waive any such claim, in whole or in part, for the convenience of the director, or if the director determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

When California is notified that a settlement or judgment has occurred, California compares the collection obtainable under the 25% and the 50% methods. California collects the lower of the twoo [sic] identified amounts unless a waiver is appropriate under Welfare and Institutions Code section 14124.71(b). If it determines that a waiver is appropriate, California further reduces the amount it could have collected under the 25% or the 50% method.

The Federal Audit

The Office of the Inspector General of Audit Services (OIGOAS) examined State records concerning TPL recoveries for the period July 1, 1988 through June 30, 1992. A universe of 2,445 cases was defined by identifying all cases with transaction codes indicating that California's TPL collection was calculated pursuant to the 50% method under Welfare and Institutions Code section 14124.78 (transaction code 449) or was reduced pursuant to the waiver method under section 14124.71(b)(2) (transaction code 440). The auditors then reviewed a random sample of 300 cases in the universe to evaluate the amount California actually collected from the TPL settlements and awards.

For each sample case, OIGOAS calculated a Medicaid "net lien" by applying California's 25% method: the total Medicaid expenditures less a percentage for attorney's fees and a pro rata share of costs. It concluded this was the amount California should have sought from the recipient's third party recovery. OIGOAS then determined whether the amount of the settlement was sufficient to compensate the attorney, pay the litigation costs, and reimburse

California for the net lien amount. If it was, OIGOAS questioned the federal share of the difference between the net lien amount and the amount California collected. If the settlement amount was not sufficient, OIGOAS questioned the federal share of the difference between the amount of the settlement less actual legal fees and costs and the amount California collected.[4]

OIGOAS found that California did not give HCFA full financial credit in 241 of the 300 cases sampled. The majority of the cases (about two-thirds) involved the 50% rule, whereby California limited its recovery to half of the amount remaining after deducting for attorney's fees, litigation costs, and out-of-pocket medical expenses. The waiver rule made up most of the balance of cases. (Miscellaneous errors, chiefly mathematical and clerical, account for the remaining, small fraction of cases.)

OIGOAS projected the results of its sample case findings to the universe of 2,445 cases. By projecting its findings, OIGOAS determined that, at a minimum, the

[4] For example, in the case of C. M. (State Exhibit 2, line 9), the recipient received $106,983 in Medi-Cal benefits, obtained a liability settlement of $150,000, and incurred $48,506 in attorney's fees and $2,641 in costs. OIGOAS calculated the "net lien" by applying California's 25% percent [sic] method: it reduced the Medi-Cal benefits by 25% to account for legal fees ($106,983 x 25% = $26,746) and $1,884 for its pro rata share of costs (($106,983 / $150,000) x $2,641 = $1,884). Thus, OIGOAS determined that the Medi-Cal net lien was $78,353 ($106,983 - $26,746 - $1,884). However, in this case, California applied its 50% method rather than its 25% method and recovered only $49,426 ($150,000 - $48,506 [legal fees] - $2,641 [costs] = $98,853 x 50% = $49,426). OIGOAS therefore determined that there was an overall deficiency of $28,927 ($78,353 [net lien] - 49,426 [California's actual recovery] = $28,927) and a shortfall in the federal reimbursement of $14,463 ($28,927 x 50% FFP = $14,463).

federal share of the amount available but not collected by California was $7,592,786. HCFA adopted OIGOAS' audit recommendations and disallowed that amount.

Analysis

California appealed this disallowance on the grounds that HCFA had unreasonably prohibited California from allowing recipients to retain portions of TPL payments which did not represent payment for medical care.

HCFA took the position that the Act requires states to fully reimburse HCFA for the federal share of medical assistance expenditures resulting from the acts of a liable third party before allowing a recipient to receive money from a TPL settlement or award. Thus, according to HCFA, a state must collect from a recipient's TPL recovery, to the maximum extent possible after deducting attorney's fees and litigation costs, the full amount of its Medicaid expenditures and remit the federal share of the expenditures to HCFA. HCFA based its position on three provisions of the Act:

- Section 1912(a)(1)(A), which requires all recipients to execute an assignment of rights "to payment for medical care from any third party;"
- Section 1902(a)(25)(B), which requires states to seek TPL reimbursement to the extent of a third party's liability;
- Section 1912(b), which provides that any amount a state collects under a recipient's assignment to payment for medical care must be used first to reimburse the Medicaid program for medical assistance payments and that the recipient is entitled only to the remainder.

HCFA's position is directly supported by these provisions of the Act. Recipients, as a condition of eligibility, must assign their rights to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to the recipient. While section 1912(a) refers to assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.

HCFA's position is also consistent with the purposes behind Medicaid TPL requirements: to make Medicaid the payor of last resort where there is a liable third party, so as to reduce Medicaid expenditures. In 1985, when Congress amended the Act to strengthen TPL recovery requirements, the accompanying legislative history provided: "Medicaid is intended to be the payor of last resort; that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." Consolidated Omnibus Budget Reconciliation Act of 1985, H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 542 (1985), reprinted in Legislative History of Titles I-XX of the Social Security Act, Vol. XXII, 99th Congress 1985-1986, Part 1. The language clearly indicates that Congress intended for the Medicaid program to be reimbursed from available third party sources to the fullest extent possible.

Moreover, California has had timely notice of HCFA's construction of the statutory provisions relating to TPL

payments since June 1988. In Medicaid Regional Memorandum No. 88-10, HCFA expressly addressed the issue of "State lien laws which permit a Medicaid recipient, who initiates pursuit of TPL recovery from a liable third party, to keep a fixed percentage of the recovered amounts before the State (and Federal Government) receives its share of the settlement." In the memorandum, HCFA instructed states that

> [i]n the absence of specific State provisions assuring full reimbursement of the Federal share, the State laws in question would be in conflict with section 1912(b). As a result, the State's actual recovery becomes impermissibly reduced such that the full Federal share (based on the total net recovery) would not be refunded. The recipient has a right only to the remainder after Medicaid payments are fully reimbursed.

HCFA Ex. C.[5]

Since California had notice of HCFA's interpretation of the Act, and that interpretation is reasonable, HCFA's interpretation is entitled to deference in this case. The Board has repeatedly stated that it will not substitute its judgment for, or overturn, a reasonable interpretation of the agency charged with administering a statute merely because there may be an alternative interpretation which arguably is also permissible. Georgia Dept. of Human

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[5] Further, in 1990, HCFA amended the State Medicaid Manual to provide that "[i]n liability situations, the Medicaid program must be fully reimbursed before the recipient can receive any money from the settlement or award." § 3907 SMM, HCFA Ex. A. Finally, in 1991, HCFA specifically informed California that its method for distributing TPL personal injury settlements and awards was out of compliance with the Act. HCFA Ex. B.

Resources, DAB No. 995 (1988); Missouri Dept. of Social Services, DAB No. 468 (1983).

California challenged HCFA's interpretation by arguing that: (1) HCFA misconstrued the law of assignment and its application in TPL cases; (2) HCFA has no right to assert a priority over funds obtained by victims; (3) HCFA misapplied section 1902(a)(25)(B) of the Act; and (4) California's TPL program complies with federal law. Below we explain why we reject California's arguments in this case.

First, California argued that HCFA misconstrued the law of assignment. It pointed out that a Medicaid recipient is required by federal law to assign only his or her rights to payment for medical care. This assignment, California argued, does not prevent a recipient from seeking recovery for other aspects of the injury such as pain and suffering and lost wages. California argued that HCFA had incorrectly assumed that all of the money a recipient recovered from a third party represented the cost of medical care.

However, HCFA did not argue that a recipient cannot seek redress for injuries beyond the cost of medical care nor did it assume that the recipient's recovery must represent only payment for medical care. Rather, HCFA's position is that, where there is a third party or casualty insurer that is responsible for paying a recipient's medical expenses, the recipient may not recover money for him/herself until the federal government is reimbursed for its expenditures for the recipient's medical care. Moreover, while arguing that HCFA incorrectly assumed that 100% of a recipient's recovery was for medical expenses, California offered no factual basis its assumption that only 50% of a recipient's recovery was medical expenses. Instead,

California simply stated that "apportionment done on a 50:50 basis is symbolically fair." California Appeal Brief at 21.

HCFA's position, that it is entitled to be reimbursed first from the recipient's tort recovery, relates to California's second argument. California asserted that HCFA has no right to a collection priority over funds obtained by Medicaid recipients in TPL suits for two reasons. First, California argued that the distribution methodology set forth in section 1912(b), on which HCFA relied, establishes a priority in favor of the federal government only when a state initiates and obtains recovery for medical care, not when a recipient brings a legal action. Second, California argued that the distribution methodology set forth in section 1912(b) concerns only payments collected pursuant to assignments for medical care and does not govern distribution of recoveries for payments which are not for medical care.

We do not find these arguments persuasive. The distribution methodology set forth in section 1912(b) must be read in conjunction with section 1902(a)(25)(B), which requires states, not recipients, to seek third party reimbursement.[6] Therefore, California has an obligation to seek

[6] Under section 1912(a)(1)(c), recipients are required to cooperate with a state's pursuit of TPL reimbursement but they are not required to pursue such reimbursement themselves. The legislative history of this provision states: "The conference agreement follows the Senate amendment with a modification clarifying that individuals are required to identify, to the extent they are able, potentially liable insurers and other third parties, and to provide information to assist the State in pursuing third parties. Beneficiaries are not required to pursue the collection [of third party reimbursement] themselves. Pursuit is the responsibility of the provider or the State as provided elsewhere in this section." H. R. Conf. Rep. No. 453, at 544-545.

third party reimbursement to [sic] "to the extent of such liability." While California has structured its tort recovery system to encourage lawsuits by recipients and private attorneys rather than the State, it would be inconsistent with the purposes of the provisions to permit this structure to obviate California's obligation under section 1902(a)(25)(B) to seek third party reimbursement or to change the distribution methodology established by section 1912(b). Further, unless these private attorneys are considered to be acting on behalf of the State so that the "collections" that they effectuate are subject to the distribution requirements of section 1912(b), then California cannot reasonably rely on their efforts as meeting the section 1902(a)(25)(B) requirement.

To allow the distribution of a settlement or an award to turn on whether a recipient or a state initiated the liability action would distort the Medicaid TPL system. Under California's construction, recipients could avoid the third party recovery mandates of the Act simply by instituting the action themselves. California identified no rational basis which would justify such divergent treatment of similarly situated recipients, or the resulting loss to the federal treasury.

California argued further that HCFA had misread section 1912(b) to create a priority for itself over all funds recovered by the recipient. California argued that such a priority ignored the fact that these payments included amounts for things other than medical care. We reject California's construction of section 1912(b) for the following reasons:

> o In cases where a third party has caused the need for medical caree [sic] and is liable for its payment, the Act looks to that third party to

reimburse the public. Section 1902(a)(25)(B) requires that "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." HCFA reasonably construed this provision to require states to pursue the full claim against a third party.

o HCFA reasonably read the Act to condition the availability of Medicaid funds on the recipient's agreement to reimburse Medicaid to the extent of a third party's liability. Therefore, Medicaid has superior status to the recipient in relation to the tortfeasor to recover costs Medicaid incurred on behalf of a recipient on the condition that it would be reimbursed if there was a liable third party from whom a recovery was collected.

o HCFA reasonably insisted on its right to characterize recoveries from third parties first as payments for medical care. This characterization prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care (e.g., by suing for pain and suffering or lost wages rather than for medical costs). Without it, TPL recoveries would be subject to a wide range of interpretations about what was appropriately considered payment for medical care.

o Even though California objected to HCFA's assertion of a priority over all the funds recovered by a recipient, its own statutory scheme asserts a priority or "first lien" over a recipient's recovery, no matter how the particular damage components of that recovery might be characterized. Cal. Welf. & Inst. Code §§ 14124.71(a); 14124.72(c) and (d); 14124.74(a) and (b). Thus,

> California recognized that such a priority is essential to effectively collect TPL reimbursement. While California's scheme goes on to limit what California may claim pursuant to its lien and gives the director authority to waive part or all of the lien, the fact is that California asserts a priority over the recipient's entire recovery.[7] Therefore, California cannot reasonably maintain that a priority over recipients' damage awards is contrary to the Act.

Third, California argued that section 1902(a)(25)(B) merely provided for a "cost based" determination as to when it was appropriate to seek third party reimbursement and did not constitute "an independent requirement that the state collect the full amount of the cost of providing medical care from the victims' settlement of their claims." California Appeal Brief, at 19. It concluded that section 1902(a)(25)(B) could not be read to "quash or supersede lawful claims of the victim." *Id.*

We disagree with California's construction of this section. Sections 1902(a)(25)(B) and 1912(b), read together,

[7] Further, we note that, until 1976, under California's prior statutory scheme for recovering Medi-Cal expenses from tortfeasors, California was given a 100% priority over the award and did not have to reduce its lien to reflect attorney's fees. The current system was enacted after several state court decisions interfered with California's ability to recover from these awards and settlements. *See Reid v. Department of Health Care Services*, 55 C.A.3d 418 (1976); *Van Nuis v. L.A. Soap Co.*, 36 C.A.3d 222 (1973). The 50% limitation was included in the final version of the current statutory scheme. It represented a codification of "long-standing settlement guidelines and was added to assure that our lien recovery could not totally deprive a beneficiary of his recovery." Enrolled Bill Report, Bill No. AB3569, dated August 19, 1976 and submitted as an attachment to California letter of November 21, 1994.

require states to seek TPL reimbursement and to distribute any collection first to the Medicaid program and then to the victim. The fact that the victim may have other "lawful claims" for such things as pain and suffering or lost wages does not override Congress' intent, as evidenced by the terms of the Act, that the Medicaid program be fully reimbursed for its expenses before the victim shares in a TPL recovery. The cost-benefit language on which California relied merely creates a common-sense exception to the general federal mandate that states seek TPL recovery. Here, we are not dealing with a few isolated incidents where a state determined that pursuit of a liable third party would not be cost-effective but the recipient nevertheless pursued recovery. Instead, California's scheme is based on recovery by recipients. Failure to apply the distribution priority established in section 1902(a)(25)(B) in these circumstances would allow a state to defeat Congressional intent.

Fourth, California argued that its "successful third party liability program is in full compliance with the federal law and regulations." California Appeal Brief, at 20. This argument focused on the effectiveness of California's TPL recovery scheme which "balances expectant costs with the potential recovery." *Id.* Specifically, California argued that, by allowing victims to share in awards, it created an incentive to seek out and pursue liable third parties, thereby maximizing pursuit and shifting initial costs from California to the victim. It argued that the 50% apportionment was fair, created "a reasonable balance between the lawful claims of the victim and California," and ended "the potential legal battle over the limited funds" in which litigants would manipulate awards and settlements to exclude medical damages. *Id.* at 20, 21. It

pointed out that its waiver authority furthered the purposes of the Act by allowing California to condition the use of funds to avoid further public expenses. Finally, it represented that all these factors resulted in a cost effective program.

We do not find these arguments persuasive for the following reasons:

o The alleged effectiveness of California's statutory scheme is not the criteria by which we must evaluate this disallowance. Rather, we must apply the Act, as reasonably interpreted by HCFA. We have explained why, under that criterion, California's system does not comply with federal law.

o The role of evaluating the practical considerations that California advanced in support of its system belongs to HCFA, not the Board. As the administering agency, HCFA has the expertise and knowledge to weigh the benefits of California's system against the adverse effects of such a system on the operation of the Medicaid program.

o As for California's assertion that its scheme created a reasonable balance between the victim and the State, that argument ignores the fact that half of the Medi-Cal funds the State is allowing the victim to keep came from the federal treasury. Consequently, HCFA is the entity which is logically charged with the responsibility of deciding what constitutes a "reasonable balance" for this aspect of the Medicaid program. To allow the many jurisdictions which participate in the Medicaid program the discretion to set that balance for third party casualty claims could undermine the TPL system and lead to divergent

treatment of similarly situated recipients. Further, as HCFA as [sic] informed California, a state is free to allow recipients to retain the state's share of the FFP if they believe that is an equitable result.

o While California maintained that the 50% apportionment is necessary to make the TPL recovery system work, HCFA could reasonably conclude otherwise. For example, even if California had complete priority over the recoveries, private attorneys would continue to have a financial incentive to take these cases because they would continue to be compensated first. Further, recipients are obligated under section 1912(a)(1)(C) to cooperate with California's pursuit of third party payment as a condition of eligibility, regardless of whether they retain any third party payment.

o Contrary to what California argued, it is not unfair completely or substantially to deny Medicaid recipients access to their settlements. If Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements. As Medicaid recipients, they do not have such debts because the public has paid their medical expenses. Therefore, in cases where Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.

o California is correct that its TPL recovery scheme, by imposing a lien on all of a recipient's recovery no matter how it is characterized, prevents recipients from structuring recoveries to exclude medical damages. However, California has the ability to prevent such problems by

amending its statutory scheme to eliminate both the 50% limit on amount it will claim and its discretion to reduce its lien.

o While California represented that its waiver method allows it to condition the use of funds to avoid further public expenses, it is free to use its share of the TPL recoveries to impose such conditions.

In summary, HCFA has the authority and the expertise to interpret the Act and to evaluate the practical considerations involved with seeking third party reimbursement from personal injury settlements and awards. In this case, HCFA has reasonably interpreted the Act to preclude systems which allow recipients to retain TPL payments from which the federal share of Medicaid expenditures has not been deducted.

Conclusion

For the preceding reasons, we uphold this disallowance.

Judith A. Ballard

Cecilia Sparks Ford

M. Terry Johnson

Presiding Board Member

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

433(D)-1-GEN;SEW

Region VIII
Federal Office Building
1961 Stout Street
Denver CO 80294

Sep 2, 1994

HEALTH CARE FINANCING ADMINISTRATION
REGIONAL IDENTICAL LETTER NO. 94-134

TO: STATE MEDICAID DIRECTORS

SUBJECT: THIRD PARTY LIABILITY RELATIONSHIP TO ISSUE OF LIENS

Federal law at section 1917(a) of the Social Security Act (the Act), and implementing regulations at 42 CFR 433.36 prohibit you from imposing liens against the property of any individual prior to his/her death because of medical assistance paid or to be paid on his/her behalf under the State plan, except in very limited circumstances.

However, section 1902(a)(25)(A) of the Act requires you to ascertain the legal liability of third parties to make payments which Medicaid would otherwise have to make. A third party is defined in the regulations at 42 CFR 433.136 as any individual, entity, or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under the State plan. This includes any monetary judgment or settlement from a tort or casualty liability claim. Where such a legal liability exists, section 1902(a)(25)(B) of the Act requires you to seek reimbursement for medical assistance payments already made.

A Medicaid recipient, at the time of application and as a condition of eligibility for Medicaid, assigns to the State his/her rights to payment from any third party and must cooperate with you in your pursuit of any third party who might be liable for payment, as required by section 1912(a)(1) of the Act. Thus, under this provision in Federal law and the implementing regulations at 42 CFR 433.145, you have claim to the amount recovered by the recipient, even though you may not have been a party to the litigation.

If, under State law, a lien is not being placed upon the Medicaid recipient's property, but rather is being placed upon the tortfeasor's (the defendant in the personal injury litigation) property or upon funds which are set aside to be used in a settlement of the litigation, but which have not become the recipient's property, then there would be no conflict with section 1917(a) of the Act. This is because section 1917(a) only precludes you from placing a lien on an individual's property.

However, under the circumstances described in this letter, you have an interest in the potential personal injury settlement when a recipient's rights to recover payment for medical care must have been assigned to you under section 1912 of the Act in order for him/her to be eligible for Medicaid. In that event, if you place a lien on these funds, it does not violate the Medicaid statute. However, you may not impose a lien on any of the recipient's property which has not been assigned to you.

If you have any questions, please call Sandra White at 303-844-6216, extension 376.

/s/ Gary Wilks
Gary Wilks
Associate Regional
Administrator
Division of Medicaid

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Region VI
1200 Main Tower Building
Dallas, Texas 75202

June 01, 1998

DALLAS REGIONAL MEDICAL SERVICES LETTER NO. 88-23

To: State Agencies Administering Approved Medical Assistance Plans

SUBJECT: State Third Party Liability (TPL) Subrogation Legislation

This is to advise you of a development in TPL subrogation legislation which is occurring in many States and which is in conflict with the Social Security Act. We refer to the passage of State lien laws which permit a Medicaid recipient, who initiates pursuit of TPL recovery from a liable third party, to keep a fixed percentage of the recovered amounts before the State (and Federal Government) receives its share of the settlement. Recently we were informed by counsel that these provisions are in conflict with Section 1912 of the Act.

Section 1902(a)(45) of the Act mandates, as a condition of eligibility, that recipients assign to the State, in accordance with Section 1912, their right to recover from third parties. Section 1912(b) of the Act states that the remainder of any amounts collected under an assignment pursuant to Section 1912(a) shall be paid to the recipient after the State recovers (with appropriate reimbursement to the Federal Government) what it paid on behalf of the recipient.

In the absence of specific State provisions assuring full reimbursement of the Federal share, the State laws in question would be in conflict with Section 1912(b). As a result, the State's actual recovery becomes impermissibly reduced such that the full Federal share (based on the total net recovery) would not be refunded. The recipient has a right only to the remainder after Medicaid payments are fully reimbursed.

While a State is certainly permitted to give part (or even all) of its recovery to a recipient, Section 1912 does not allow a State to give away the Federal share. Moreover, since Title XIX does not authorize any payments to the recipient until Medicaid is fully repaid, any payment to recipients can be made only after the State has credited its recovery and established the amount of the Federal share to be returned.

Furthermore, the only amounts which can be paid out prior to State recoupment are legitimate administrative expenses. This is based upon an interpretation of "net recovery" in Section 1903(d)(3) of the Act, which speaks about the pro rata share of the recovery to which the United States is equitably entitled. "Net recovery" is interpreted to mean the settlement amount less procurement costs, including attorney fees. The regulation which discusses the basic rule is applicable to Medicare beneficiaries (42 CFR 405.423(b) and (c)), but, by analogy, a similar application to Medicaid recipients can be made.